

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 103. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
04243

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04228

1. DECEASED NAME (Type or Print) Alcincla Addison			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MATED <input type="checkbox"/> 3 16 1968			2b. HOUR 4:45 AM				
3. SEX Fe-	4. RACE Colored	5. DATE OF BIRTH March 8 1888	6. AGE (in years last birthday) 80 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month 3 Day 16 Year 1968			2d. HOUR 5:45 AM	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1001 Norwood Dr.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER 1001 Norwood Dr.				
14. FATHER'S NAME Noah			15. MOTHER'S MAIDEN NAME Rachel			16. SOCIAL SECURITY NO.				17. INFORMANT Warfield.
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT				ADDRESS
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia - 486x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 493x										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE John S. Bell			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED March 16, 1968				
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
			ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)	
Burial			Mar. 20, 1968			Ash Memorial			Sandy Spring Montg. Md.	
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE	
Robert L. Snowden			Rockville Md.			MAR 26 1968			Charles Judge	



COG20

COG20



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR			
James S. Albertson						March 14 1968			9 PM			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
M.		W.		11/30/01			66 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			
New York			U.S.A.						Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda			Suburban			Minister						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
D.C.			D.C.			Washington			5133 Broad Burn Rd			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
James S. Albertson			Elizabeth Whittingham									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address			
No			230-48-5226			Mr James S. Albertson Jr.			3513 Northampton Whittier			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular disease											5 YRS	
4120												
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
(b) DUE TO, OR AS A CONSEQUENCE OF												
(c) DUE TO, OR AS A CONSEQUENCE OF												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)												
443X												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1948, to 14 MAR 1968, that (I) (we) last saw the deceased alive on 14 MAR 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS			
John M. Wyman			3/15/68			JOHN M. WYMAN			7801 NORFOLK AVE, BETHESDA, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial			3-18-68		Ft. Lincoln Cem.		Prince George County, Md.					
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
ROBERT A. PUMPHREY, Bethesda, Maryland			MAR 26 1968			Charles Judge						



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1

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

042311

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRINGS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>90 SYLVAN MANOR NURSING HOME</u>		d. STREET ADDRESS <u>6512 QUEENS CHAPEL RD.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>PAULINE ALEXANDER</u>		4. DATE OF DEATH Month Day Year <u>MARCH 10 19 68</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 1879</u>
9. AGE (In years and months) <u>88 yrs.</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Abraham Schwartz</u>		14. MOTHER'S MAIDEN NAME <u>Lochla Fischer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Arthur Weyman</u>		Address <u>6512 Queens Chapel Rd Hyattsville</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4272 CARDIAC ARREST</u> DUE TO (b) <u>CEREBRAL INSUFFICIENCY</u> DUE TO (c) <u>SENILITY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>10 MIN.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4330</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1958</u> , to <u>3-10-1968</u> , that (I) (we) last saw the deceased alive on <u>2-29-1968</u> , and that death occurred at <u>12¹⁵</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Samuel A. Hillman</u> M.D.		22b. DATE SIGNED <u>3-10-68</u>	
22c. PHYSICIAN'S NAME (Type) <u>SAMUEL A. HILLMAN</u>		22d. ADDRESS <u>8829-FLORIAN AVE. S.S. Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>3/11/68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Capitol View Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Capitol Heights Md.</u>
24. FUNERAL DIRECTOR <u>Samuel Dargatzis & Sons - 3501 14th St. N.W. Wash. DC</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 14 1968</u>	25b. REGISTRAR'S SIGNATURE <u>John Charles Young</u>

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12/2/21

12/2/21

12/2/21

_____ of the County of _____ State of _____
do hereby certify that _____
is the duly authorized representative of _____
and is authorized to execute the foregoing instrument
and all other instruments which may be required
in connection with the same.

_____ Secretary of State

NOTARY PUBLIC FOR THE STATE OF TEXAS
My Commission Expires _____
I am Notary Public for the State of Texas
My Commission Number is _____

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print) <i>David Lowell Anderson</i>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MATED <input type="checkbox"/> <i>Mar 9</i>		2b. HOUR <i>10:15 A.M.</i>		2c. DATE PRONOUNCED DEAD <i>3-9-68</i>	
3. SEX <i>male</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>1/27/68</i>		6. AGE (In years last birthday) <i>1 11</i>		IF UNDER 1 YEAR MONTHS <i>1</i> DAYS <i>11</i>		IF UNDER 24 HRS. HOURS <i>1</i> MIN. <i>11</i>	
7a. BIRTHPLACE (State or foreign country) <i>D.C.</i>			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i>		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Infant</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md</i>			13b. COUNTY <i>Mont</i>			13c. CITY OR TOWN <i>Calverton</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First <i>Donald G.</i> Middle <i>Anderson</i> Last <i>Anderson</i>			15. MOTHER'S MAIDEN NAME First <i>Nancy</i> Middle <i>Wright</i> Last <i>Wright</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>- - -</i> (If yes give war or dates of service)					
16b. SOCIAL SECURITY NO. <i>- - -</i>						17. INFORMANT <i>MRS. D.G. ANDERSON</i> ADDRESS <i>Same as above</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Diffuse Bilateral</i> <i>480X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Pneumonitis of probable</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Viral Etiology</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>492X</i>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>19</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Belden R. Reap</i>		EXAMINER'S NAME (Type) <i>BELDEN R. REAP, M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>MAR. 9, 1968</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3-12-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arlington Nat'l. Cemetery</i>		23d. LOCATION (City or Town) <i>Arlington</i> (County) <i>XXXXXXX</i> (State) <i>MD</i>		24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc.</i> ADDRESS <i>5130 Wisc. Ave. N.W. Wash. D.C.</i>			
25a. REC'D BY REGISTRAR <i>MAR 13 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>									

U.S. DEPARTMENT OF AGRICULTURE

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and 7 and 8, and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours of the death. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours of the death.

Item 6 Film G399 1/10/68 W. DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last EULA R ANDERSON			2a. DATE OF DEATH Month Day Year MARCH 22 1968			2b. HOUR 8:45 PM	
3. SEX FEMALE		4. RACE NEGRO		5. DATE OF BIRTH OCTOBER 7 1883		6. AGE (In years last birthday) 84 YRS.	
7a. BIRTHPLACE (State or foreign country) GEORGIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) FAIRLAND NURSING HOME 2101 FAIRLAND ROAD		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE WASHINGTON, D.C.		13b. COUNTY V		13c. CITY OR TOWN V		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last BENJAMIN RAMBEAU		15. MOTHER'S MAIDEN NAME First Middle Last COLLIER		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 578-68-5163	
17. INFORMANT		Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 437.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 331X (b) Cerebral ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) Generalized ARTERIOSCLEROSIS PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes mellitus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 4 YRS 4 YRS	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State		22a. SIGNATURE R.T. Benack MD		22b. DATE SIGNED 3/22/68	
22c. PHYSICIAN'S NAME (Type) R.T. Benack MD		22d. ADDRESS 4115 Colie Dr. Wheaton MD		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3/26/68	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) DONALSONVILLE, GA.		24. FUNERAL DIRECTOR Robt. J. McInire		25a. REC'D BY REGISTRAR MAR 26 1968	
25b. REGISTRAR'S SIGNATURE James J. ...		25c. ADDRESS 1820-9th St. N.W. A.C.		25d. DATE MAR 26 1968		25e. REGISTRAR'S SIGNATURE James J. ...	

1

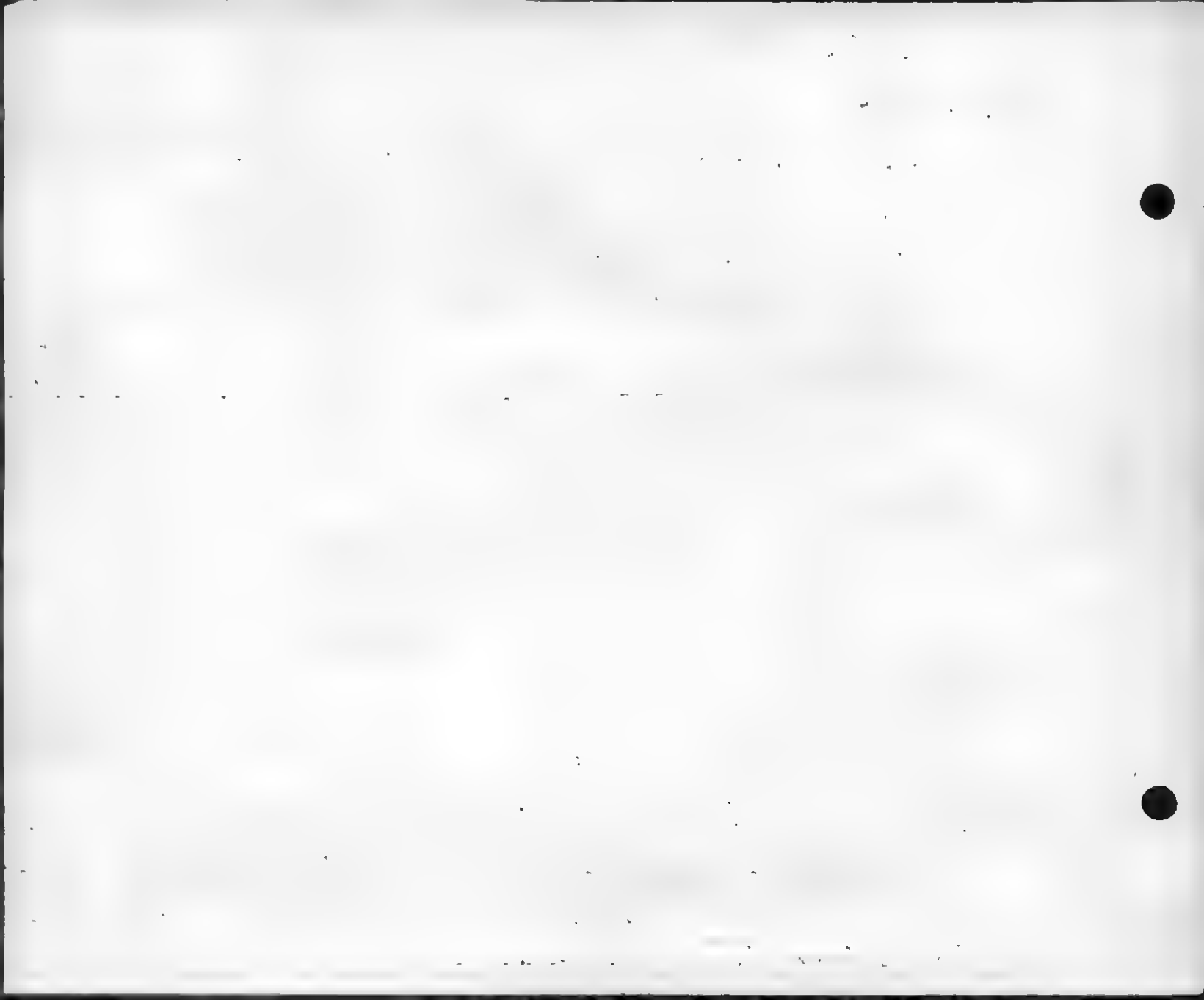
THE UNIVERSITY OF CHICAGO LIBRARY

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MD245
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

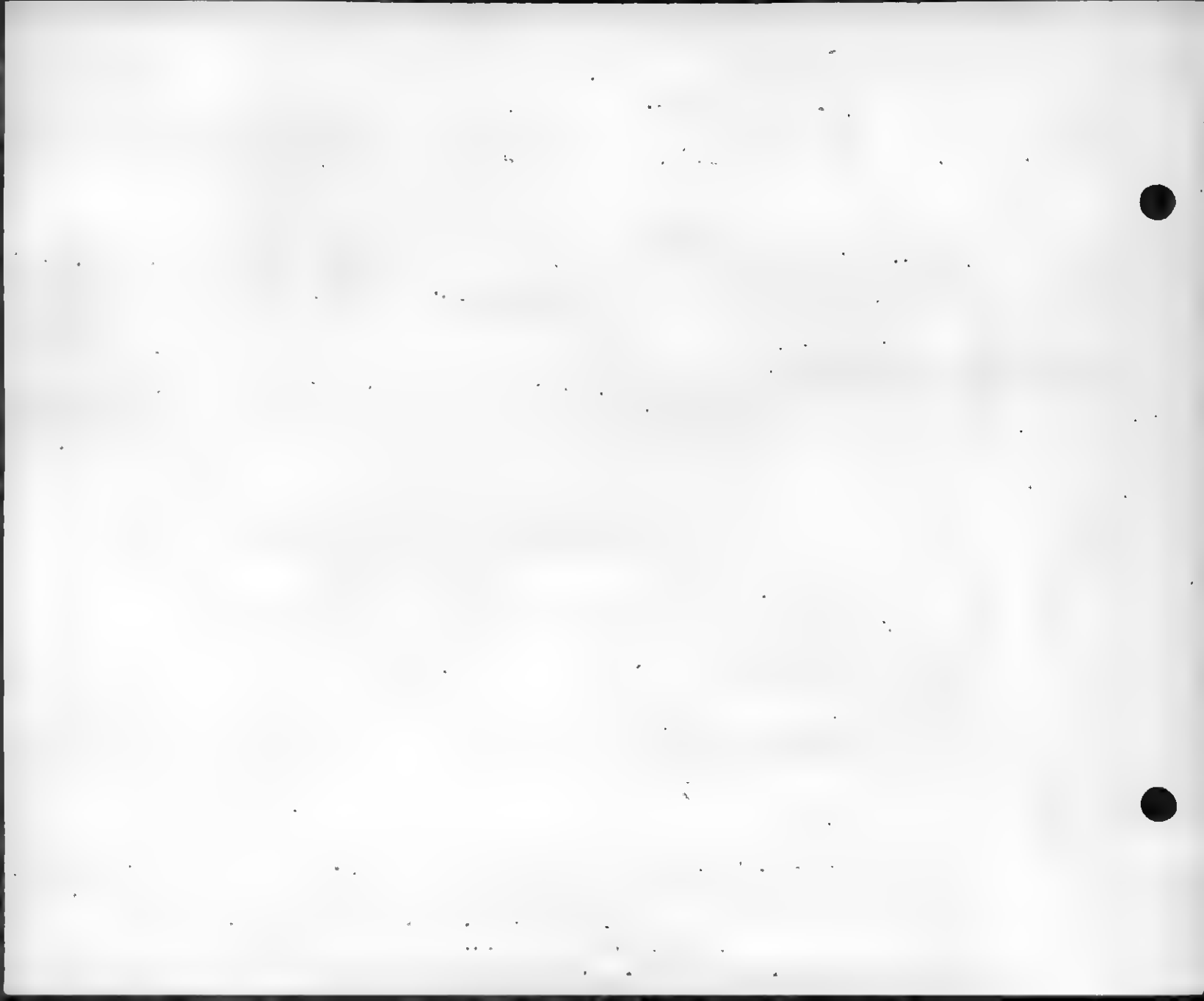
1 DECEASED-NAME (Type or print) Margaret			First J			Middle AUKWARD			Last AUKWARD			2a. DATE OF DEATH Month 3 Day 14 Year 68			2b. HOUR 8:50 P M					
3 SEX Female			4 RACE WHITE			5 DATE OF BIRTH 10-23-94			6. AGE (n years lost birthday) 73 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			IF UNDER 24 HRS.					
7a BIRTHPLACE (State or foreign country) Ireland			7b CITIZEN OF WHAT COUNTRY? U. S. A.			8- MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH MONTGOMERY COUNTY Md											
10 CITY OR TOWN OF DEATH Silver Spring			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Nurse			12b. KIND OF BUSINESS OR INDUSTRY Nursing											
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY MONTGOMERY			13c CITY OR TOWN Silver Spring			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			3e STREET AND NUMBER 10411 Clinton Avenue								
14. FATHER'S NAME First Michael			Middle Reidy			Last Catherine			15 MOTHER'S MAIDEN NAME First Catherine			Middle Connor			Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 214-52-5665			17. INFORMANT Mr. John C. Aukward 9817 E. Light Dr. S.S., MD.			Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Heart failure 140.1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 45																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home farm, street, factory, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town			County			State					
22a. I certify that (I) (this hospital) attended the deceased from 1957 to Mar 14, 1968 , that (I) (we) last saw the deceased alive on Mar 14, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE Edward J. Richards M.D. DEGREE															ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED March 14, 1968		
22d. PHYSICIAN'S NAME (Type) Edward J. Richards M.D.			22e. ADDRESS 10110 Georgia Avenue Silver Spring, Md.																	
23a. BURIAL, CREMATON, REMOVAL (Specify) Interment			23b. DATE 3/18/68			23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.			23d. LOCATION (City or Town) Arlington			(County) Arlington			(State) Va.					
24. FUNERAL DIRECTOR Garner F. Pumphrey, Inc., 8434 Ga. Ave. S.S., Md.																				
25a. REC'D BY REGISTRAR DATE			25b. REGISTRAR'S SIGNATURE MAR 19 1968																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copy papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last FRANCIS M. BALL						2a. DATE OF DEATH Month Day Year March 1 1968			2b. HOUR 12 AM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH May 25 1876		6. AGE (In years last birthday) 91 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md					
10. CITY OR TOWN OF DEATH KENSINGTON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) KENSINGTON GARDENS SANIT			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) RETIRED			12b. KIND OF BUSINESS OR INDUSTRY N/A		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE DIST. OF COL.			13b. COUNTY —		13c. CITY OR TOWN WASHINGTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2931 KANAWHA ST., N.W.		
14. FATHER'S NAME First Middle Last MORTON D. BALL				15. MOTHER'S MAIDEN NAME First Middle Last SALLIE L. WRIGHT							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes, specify) NO		16b. SOCIAL SECURITY NO 568-43 8114		17. INFORMANT Address ALICE D. BALL-DTR.-SAME AS #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral Thrombosis 4339 DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arteriosclerosis											
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? not done					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year None 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) None							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) None		21f. LOCATION Street or R.F.D. No. City or Town County State 220 1962 injury							
22a. I certify that (I) (this hospital) attended the deceased from January 1962, to March 10, 1968, that (I) (we) lost saw the deceased alive on February 29, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE James M. Loftus						22c. DATE SIGNED March 1, 1968					
22d. PHYSICIAN'S NAME (Type) James M. Loftus						22e. ADDRESS 5415 Conn. Ave., N.W., WASH., D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/5/68		23c. NAME OF CEMETERY OR CREMATORY Lewinsville Presb. Cem.		23d. LOCATION (City or Town) (County) (State) Mc Lean, Virginia					
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Washington, D.C. 20016						25a. REC'D BY REGISTRAR DATE MAR 8 1968		25b. REGISTRAR'S SIGNATURE Charles Jones			



FOR STATE HEALTH DEPT

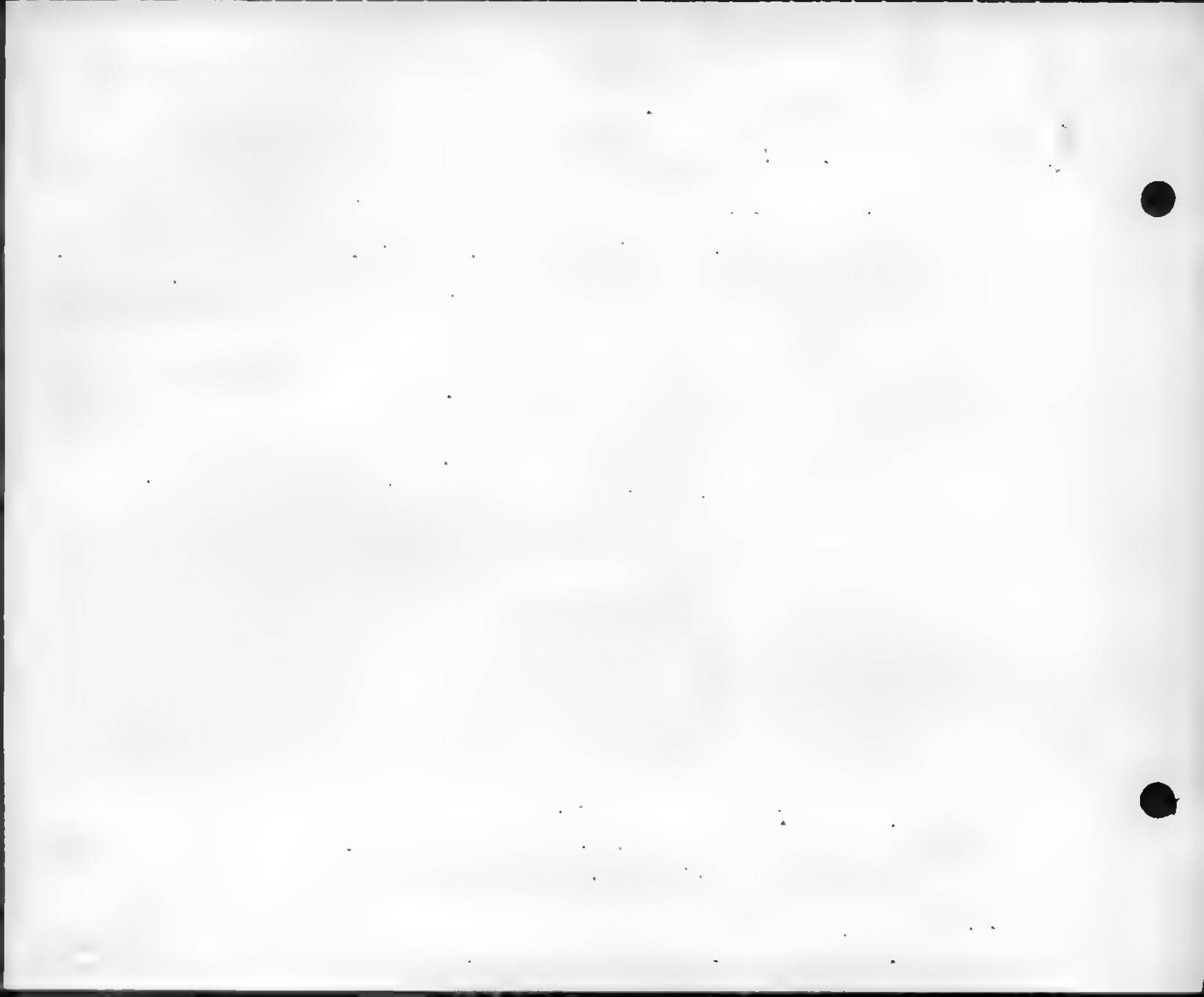
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) Robert A. Barbee			2a DATE KNOWN OF DEATH Month 3 Day 26 Year 1968			2b HOUR 7:45 AM		
3 SEX Male	4 RACE White	5 DATE OF BIRTH 10-14-1977	6 AGE (in years last birthday) 89 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month 3 Day 26 Year 1968		
7a BIRTHPLACE (State or foreign country) Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery		
10 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 9809 Capitol View Ave.				12a USUAL OCCUPATION (Kind of work done during most of work life even if retired) Retired		12b KIND OF BUSINESS OR INDUSTRY Gov't.
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland			13b COUNTY Montgomery		13c CITY OR TOWN Silver Spring		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 9809 Capitol View Ave.			14 FATHER'S NAME William Barbee			15 MOTHER'S MAIDEN NAME Susan		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b SOCIAL SECURITY NO 412-9		17 INFORMANT Robert A. Barbee			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic Heart Disease (b) 412.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) 412.9 PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 412.9								
19a. DATE OF OPERATION 4-1-68			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Belden R. Reep		EXAMINER'S NAME (Type) BELDEN R. REEP, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED 3/26/1968		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE March 28 '68		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d LOCATION (City or Town) (County) (State) Rockville Montgomery Maryland		
24 GENERAL DIRECTOR C. Glen Carter				ADDRESS 8434 Georgia Avenue		25a REC'D BY REGISTRAR Charles Judge		25b REGISTRAR'S SIGNATURE Charles Judge
Funeral Home Funeral S. Pembrey, Inc.				ADDRESS Silver Spring, Maryland		DATE MAR 29 1968		

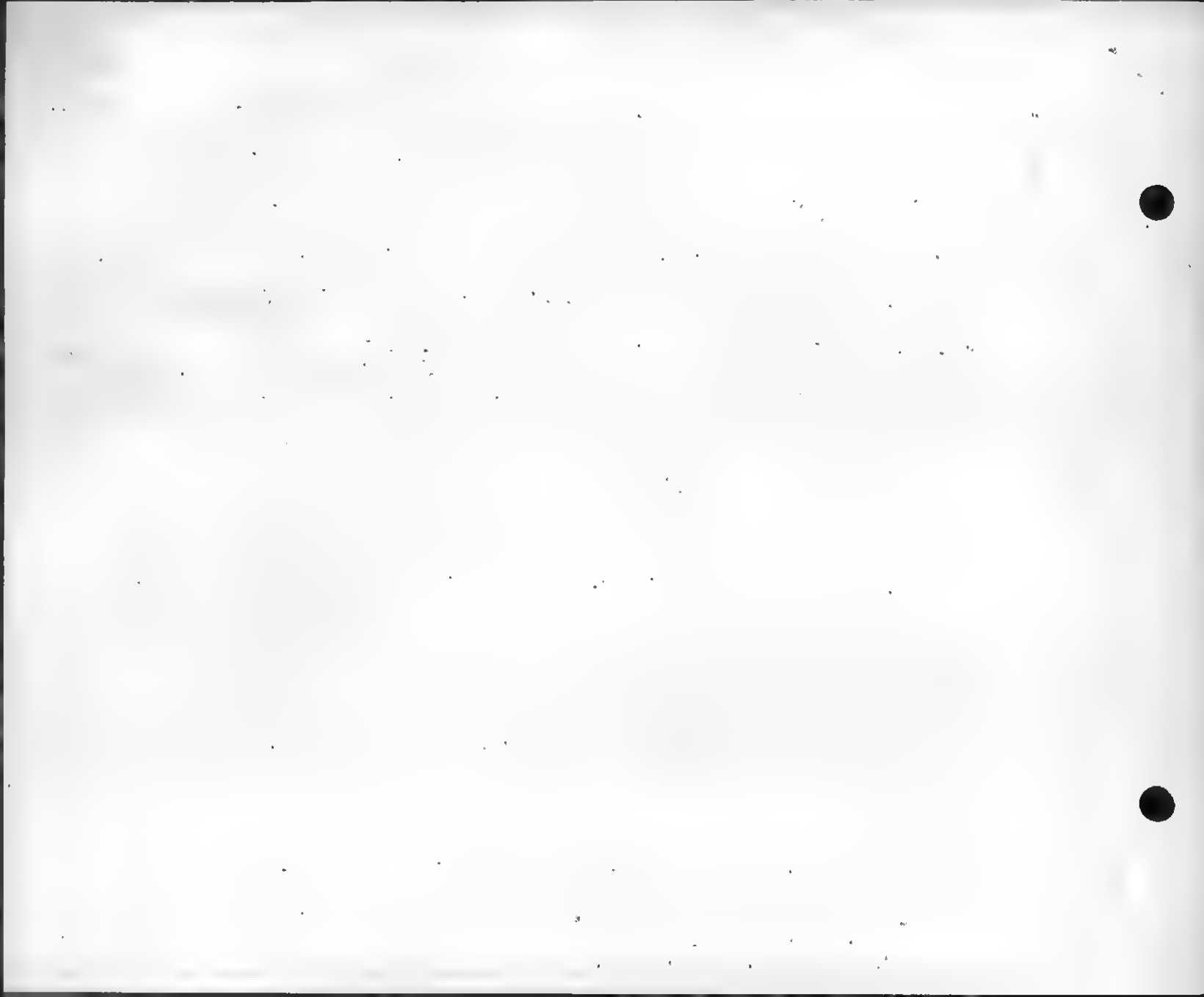


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MD 251
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last James C. BARLOW			2a. DATE OF DEATH Month Day Year March 31 1968			2b. HOUR P 940 M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH May 16, 1905		6. AGE (In years lost birthday) 62 YRS	
7a. BIRTHPLACE (State or foreign country) Star, Mississippi		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Naval Hospital		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired.) Officer, USAF		12b. KIND OF BUSINESS OR INDUSTRY USAF	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Virginia		13b. COUNTY Fredericksburg		13c. CITY OR TOWN Fredericksburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 115 Lake Shore Drive		14. FATHER'S NAME First Middle Last Wiley G. Barlow		15. MOTHER'S MAIDEN NAME First Middle Last Sally Lawson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO (If yes give war or dates of service) 1922-1951		17. INFORMANT Fredericksburg, Address Virginia Mrs. Ethel P. Barlow, 115 Lake Shore Drive			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Resected aspergillus</i> 2000 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2043 (b) <i>Acute myelogenous leukemia</i> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Hypertensive and atherosclerotic cardiovascular disease</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (1) (this hospital) attended the deceased from <u>Mar. 14</u> , 19 <u>68</u> , to <u>Mar. 31</u> , 19 <u>68</u> , that (1) (we) last saw the deceased alive on <u>March 31</u> , 19 <u>68</u> , and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>James W. Lea, Jr. M.D.</i>		22c. DATE SIGNED 1 April 1968		22d. PHYSICIAN'S NAME (Type) James W. Lea, Jr. M. D.		22e. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-4-68		23c. NAME OF CEMETERY OR CREMATORY Harrisville, Cemetery		23d. LOCATION (City or Town) (County) (State) Harrisville, Mississippi	
24. FUNERAL DIRECTOR Robert A. Pumphrey ADDRESS Funeral Home, 7557 Wisconsin Ave., Bethesda,				25a. REC'D BY REGISTRAR APR 3 - 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

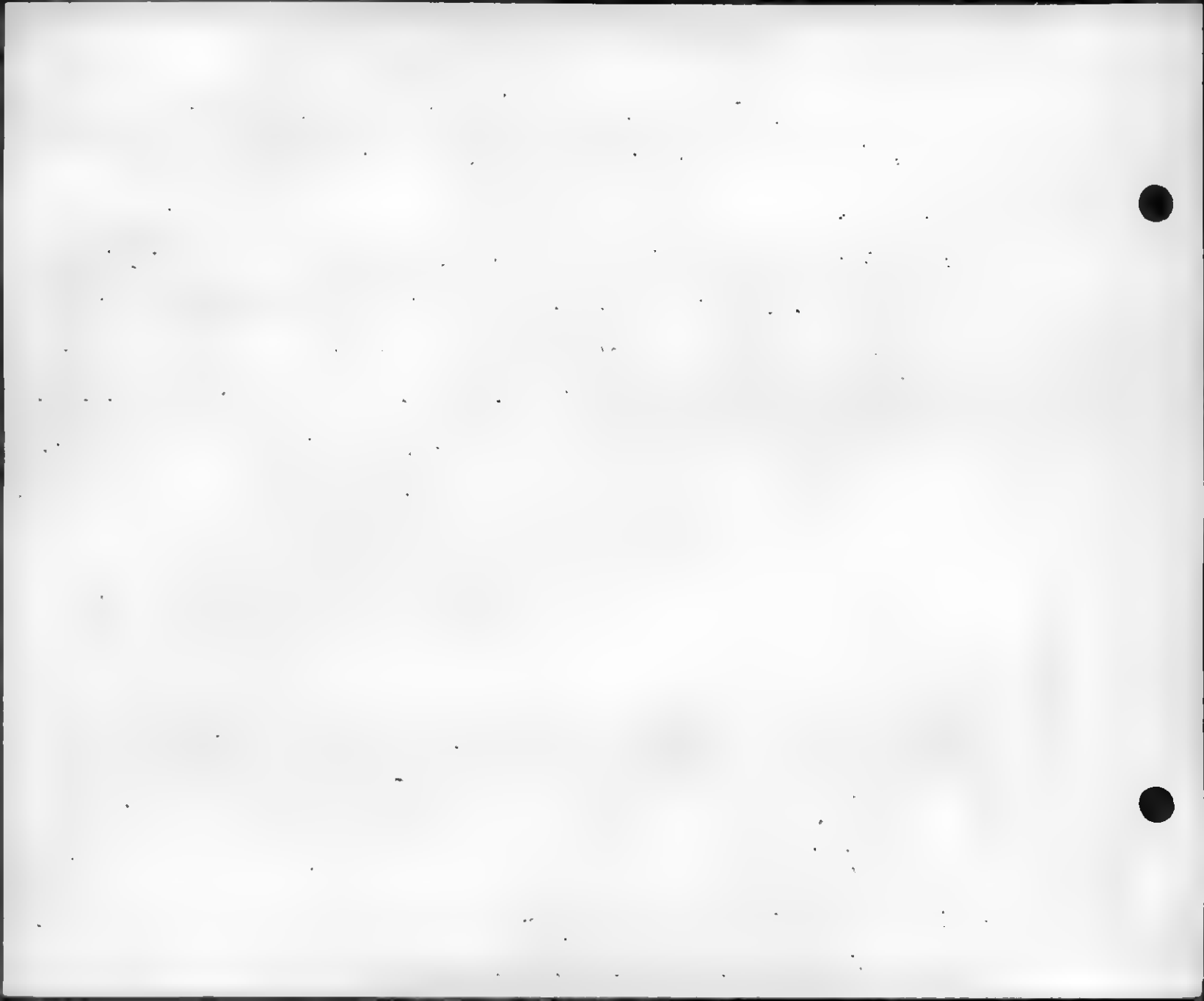


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MD 252
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Herbert G. Barott		First Middle Last		2a. DATE OF DEATH Month March Day 22 Year 1968		2b. HOUR 3:40 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH July 13, 1881		6. AGE (In years lost birthday) 86 YRS	
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Silver Spring, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired		12b. KIND OF BUSINESS OR INDUSTRY Physician	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Maryland 13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1307-Naves Drive	
14. FATHER'S NAME First Henry Middle H Last Barott		15. MOTHER'S MAIDEN NAME First Laverna Middle - Last -					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <input checked="" type="checkbox"/> No		16b. SOCIAL SECURITY NO. 220-44-4411		17. INFORMANT Address Mrs. Ella C. Barott 1307 Naves Drive S.S., Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) +41.2 Anuria, Uremia syndrome DUE TO, OR AS A CONSEQUENCE OF (b) Abdominal acute aneurysm involving renal artery, several months DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD Year PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 421							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 days
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from May , 19 65 , to March 21 , 19 68 , that (I) (we) last saw the deceased alive on March 21 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Hugo G. Graziani, M.D.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/22/68	
22d. PHYSICIAN'S NAME (Type) HUGO G. GRAZIANI, M.D.		22e. ADDRESS 10101 Georgia Ave S.S., Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) 220		23b. DATE 3/25/68		23c. NAME OF CEMETERY OR CREMATORY Bartholomew Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Montgomery Md.	
24. FUNERAL DIRECTOR Warner S. Pumphrey Inc. 8434 Co. Ave. S.S., Md		25a. REC'D BY REGISTRAR 1968		25b. REGISTRAR'S SIGNATURE [Signature]		DATE	

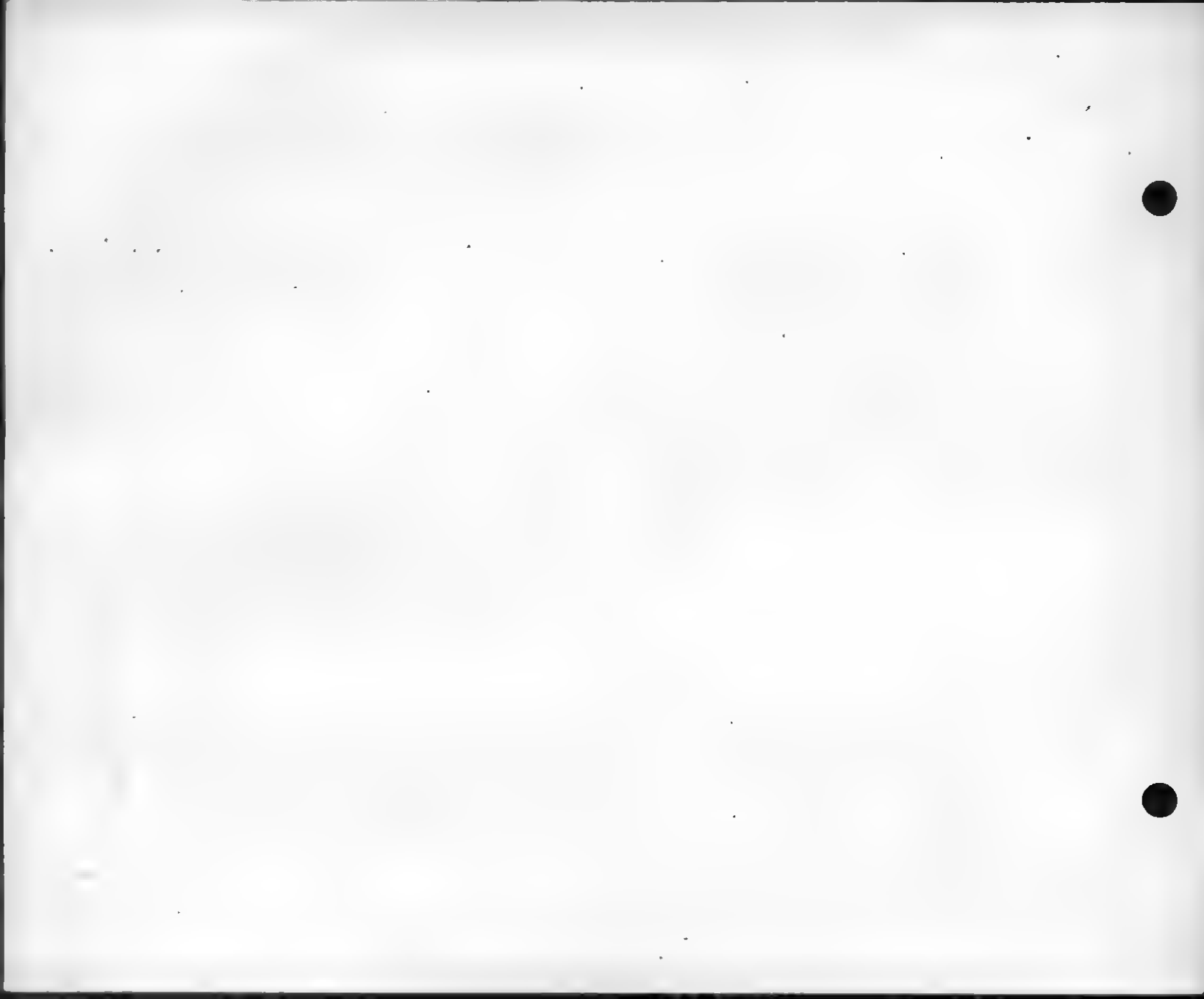


FOR STATE HEALTH DEPT.

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<div>Item 18b Film 3-9 4-10</div> <div>2253</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div>											
1 DECEASED NAME (Type or Print) <i>William Horace Barrett</i>			First <i>William</i> Middle <i>H.</i> Last <i>Barrett</i>			2a DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 3 15 1968			2b HOUR <i>7 A M</i>		
3 SEX <i>M</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>7/11/1917</i>		6 AGE (In years last birthday) <i>50</i> YRS		IF UNDER 1 YEAR MONTHS DAYS		F UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <i>New York</i>			7b CIT ZEN OF WHAT COUNTRY? <i>USA</i>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i>		
10 CITY OR TOWN OF DEATH <i>Rockville</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>651 Azalea Drive</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Lawyer</i>			12b KIND OF BUSINESS OR INDUSTRY <i>U.S. Gov't.</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Montgomery</i>			13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>651 Azalea Drive</i>	
14. FATHER'S NAME First <i>Jacob</i> Middle <i>Bernstein</i> Last <i>Bernstein</i>						15. MOTHER'S MAIDEN NAME First <i>Sophia</i> Middle <i>Cohen</i> Last <i>Cohen</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>			16b. SOCIAL SECURITY NO <i>005-18-7467</i>			17. INFORMANT ADDRESS <i>Estelle M. Barrett-Items 10 & 11</i>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypoxia - 951X</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Decreased oxygen & Barbiturates</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>lost.</i>										APPROX MATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hr. ?</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>none</i>											
19a. DATE OF OPERATION <i>3/15/68</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				19c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PR. MARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CASE OF DEATH			21b. TIME OF INJURY Month, Day, Year <i>3 15 1968</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Cardiac arrest after 1st stage of anesthesia for removal of gallbladder</i>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc) <i>Home</i>			21f. LOCATION Street or RFD No <i>651 Azalea Drive</i> City or Town <i>Rockville</i> County <i>Montgomery</i> State <i>Md</i>					
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect an <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John G. Ball</i>						CHIEF MED CAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>3/16/68</i>		
EXAMINER'S NAME (Type) <i>John G. Ball</i>						ASS. STANT MED CAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>			23b. DATE <i>3/16/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>			23d. LOCATION (City or Town) (County) (State) <i>Prince George Co., Maryland</i>			
24. FUNERAL DIRECTOR <i>Funeral Home-1331 Rockville Pike Rockville, Md.</i>						25a. REC'D BY REGISTRAR <i>MAR 19 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles J. Judge</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

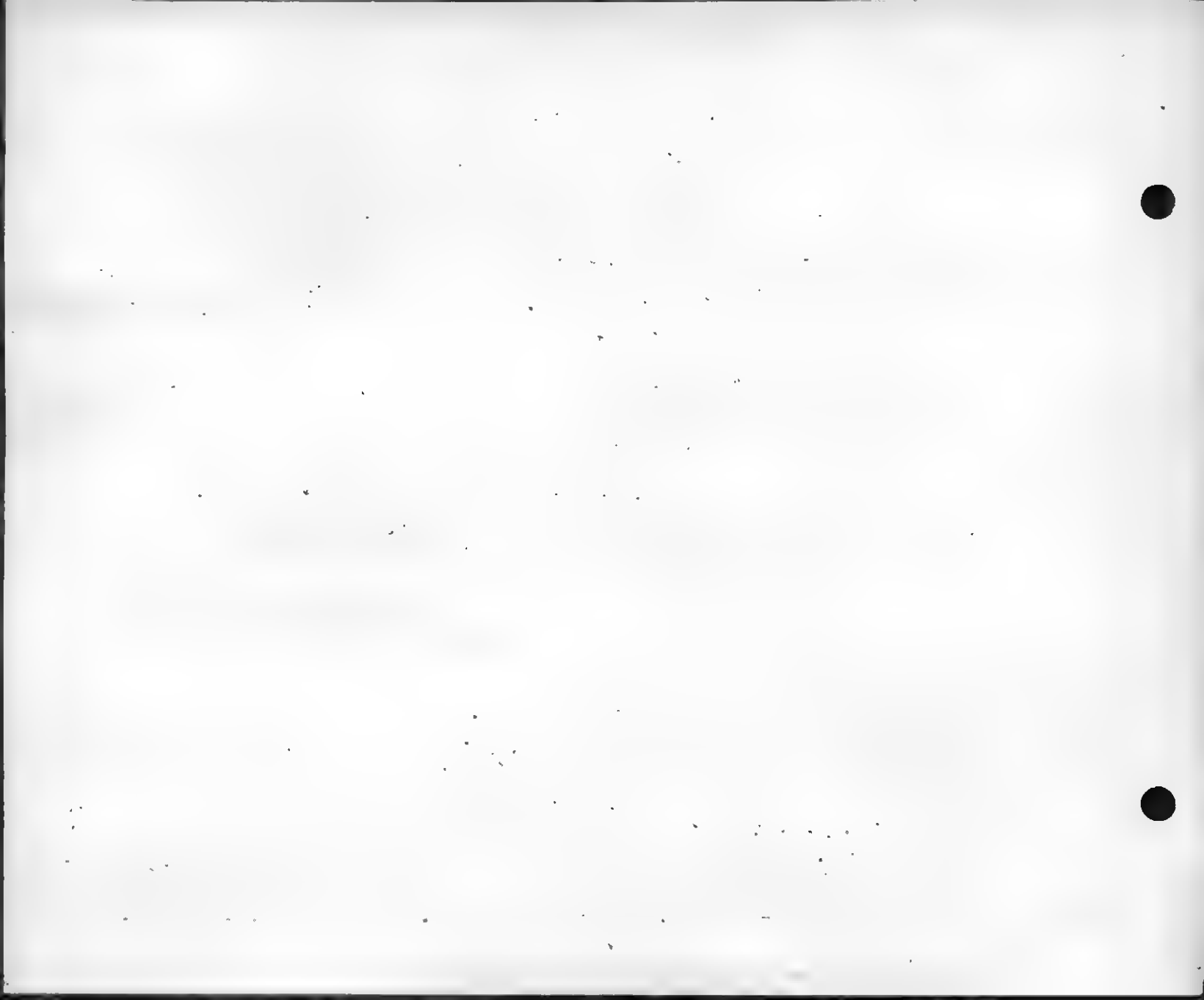
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

6254

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Margaret K Basala</i>			2a. DATE OF DEATH Month <i>March</i> Day <i>9</i> Year <i>1968</i>			2b. HOUR <i>17:30</i> PM	
3. SEX <i>F</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>11-29-88</i>		6. AGE (In years last birthday) <i>79</i> YRS.		7. UNDER 1 YEAR MONTHS <i>1</i> DAYS <i>10</i> HOURS <i>10</i> MIN	
7a. BIRTHPLACE (State or foreign country) <i>TEXAS, MD.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Montgomery</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Bethesda</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>8104 Maple Ridge Rd</i>		14. FATHER'S NAME First <i>JOHN</i> Middle <i>H</i> Last <i>KEATING</i>		15. MOTHER'S MAIDEN NAME First <i>MARY</i> Middle <i>A</i> Last <i>CONNOR</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO <i>Unknown</i>		17. INFORMANT <i>J. ALBERT BASSIE</i> (husband) Address <i>Above</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Hepatic failure</i> <i>35x</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Stricture Ampulla of Vater</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diverticulum of Duodenum</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>45x</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D.-No. City or Town County State <i>2129/68</i>			
22a. I certify that (I) (this hospital) attended the deceased from <i>3/19/68</i> , 19 <i>68</i> , to <i>3/19</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>3/19</i> , 19 <i>68</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Frederick J. Donnan</i>				22c. DATE SIGNED <i>3/19/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>F. J. DONNAN</i>				22e. ADDRESS <i>10400 Connecticut Ave, Kensington, Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>3-13-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Maryland</i>	
24. FUNERAL DIRECTOR <i>Robert A. Humphrey</i>		ADDRESS <i>Bethesda, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>MAR 14 1968</i>		25b. REGISTRAR'S SIGNATURE <i>James J. J...</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

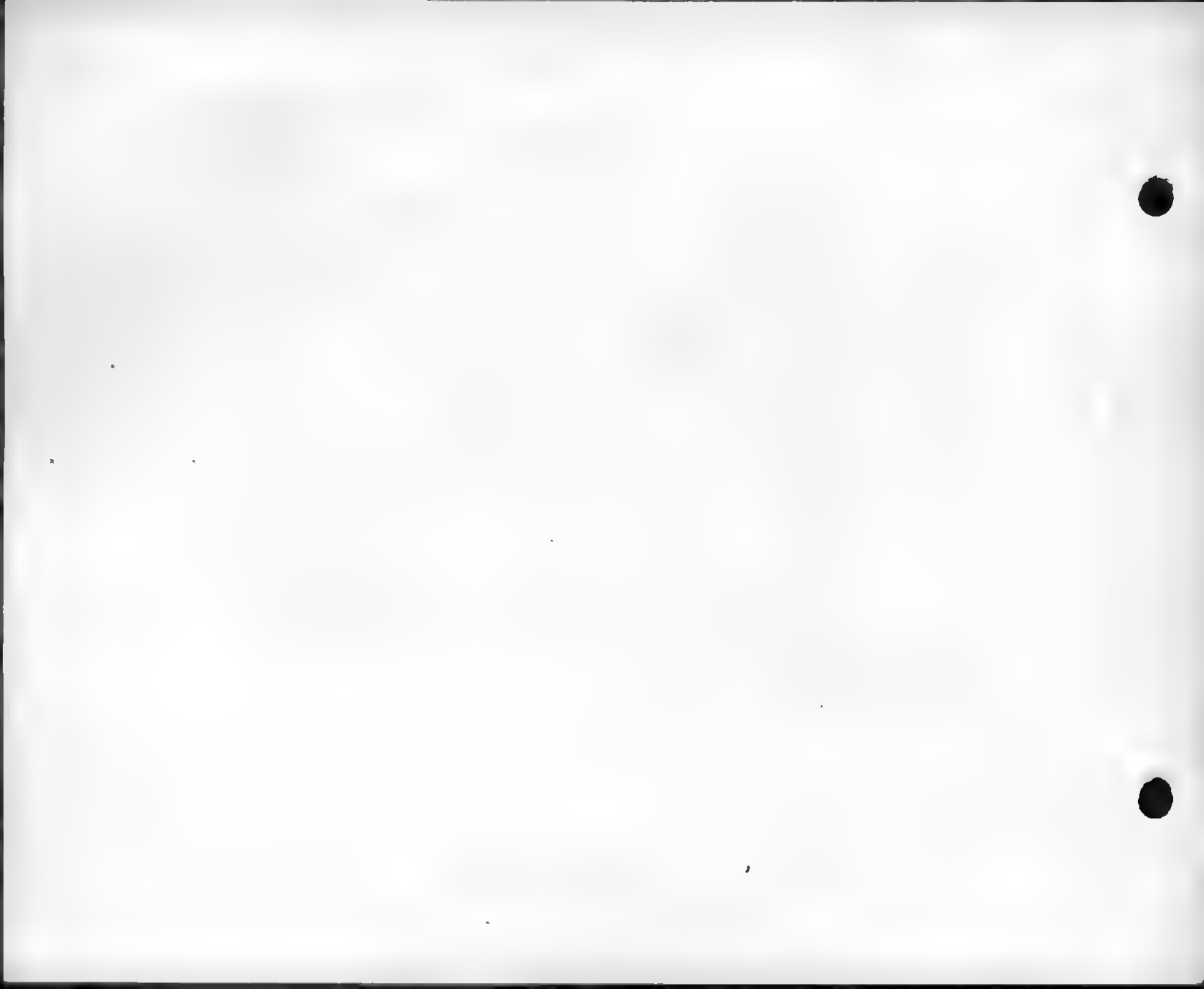
3425

CERTIFICATE OF DEATH

9 41

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Highland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery General</u>				d. STREET ADDRESS <u>Hink Hollow Road</u>			
3. NAME OF DECEASED (Type or print) <u>Virgie M Beavers</u>				4. DATE OF DEATH Month <u>March</u> Day <u>7</u> Year <u>19 68</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/28/03</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 Year Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			
13. FATHER'S NAME <u>Wallace Mobley</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth unknown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>unknown</u>		17. INFORMANT <u>records: Montgomery Gen. Hosp., Olney, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cochexia</u> DUE TO <u>Metastatic Pancreas CA.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>carcinoma Pancreas</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>2 Mo.</u> <u>5 Mo.</u> <u>30 Mo.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>157X</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 1967, to <u>Mar 7</u> , 1968, that (I) (we) lost saw the deceased alive on <u>Mar 7</u> , 1968, and that death occurred at <u>10:30 PM</u> from causes and on the date stated above.					
22a. SIGNATURE <u>Donald R. Lewis</u>		22b. DATE SIGNED <u>Mar 7, 68</u>		22c. PHYSICIAN'S NAME (Type) <u>Donald R. Lewis, M.D.</u>			
22d. ADDRESS <u>700 Cloverly st., Silver Spring, Md.</u>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>March 11-1968</u>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>St. Francis</u>			
23d. LOCATION (City or town) (County) (State) <u>Bellevue, Md.</u>		24. FUNERAL DIRECTOR <u>Arthur Walters</u>					
25a. REC'D BY REGISTRAR <u>11 1968</u>		25b. REGISTRAR'S SIGNATURE <u>James Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.



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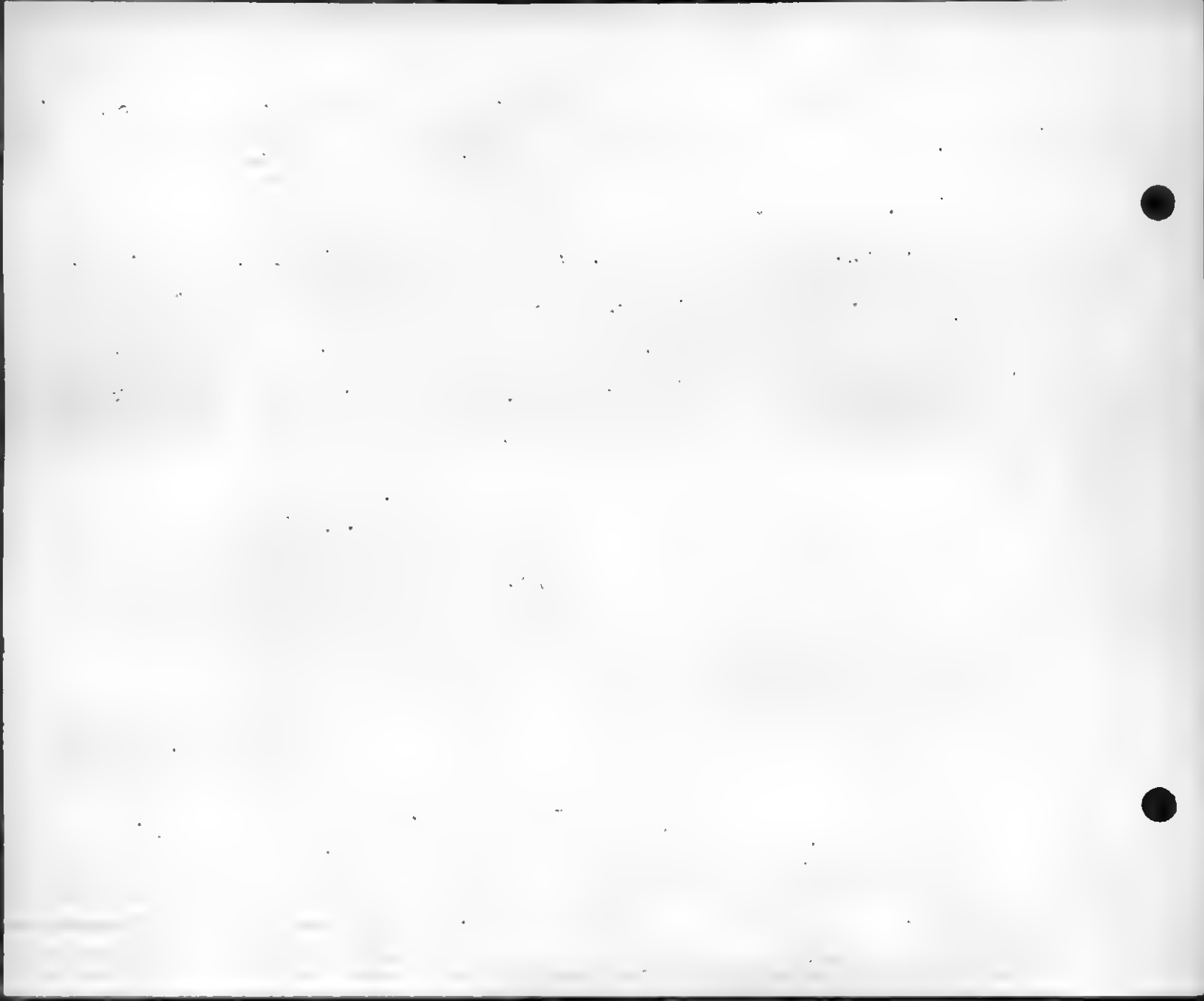
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Cleared with Medical Examiner - 7/28/68

VR A15 M
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last PAULINE S. BREMER			2a. DATE OF DEATH Month Day Year 3 29 1968			2b. H.O.I.R. 729 M	
3 SEX Female		4 RACE White		5 DATE OF BIRTH Aug. 27, 1904		6 AGE (In years last birthday) 63 YRS.	
7a. BIRTHPLACE (State or foreign country) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Private Secretary		12b. KIND OF BUSINESS OR INDUSTRY Am. Red Cr.	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Sp.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 3803 Kayson Street		14. FATHER'S NAME First Middle Last John W. Shannon		15. MOTHER'S M.A.D.N. Name First Middle Last Adelaide Melchior			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 579-44-5649		17 INFORMANT John Beemer - 3803 Kayson St. Sil. Sp., Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aortic Stenosis & Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary thrombosis, acute</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15"</u> <u>10 & 54"</u> <u>15"</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>1) Subaortic stenosis, 2) A.S.H. Dis., 3) Recurrent A.V. Fib.</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>1948</u> to <u>present</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7-10-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. <u>DR B. REAP - NOTIFIED</u>							
22b. SIGNATURE <u>Francis J. Murray MD</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <u>3-29-68</u>			
22d. PHYSICIAN'S NAME (Type) Francis J. Murray				22e. ADDRESS <u>1601 18th St NW</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4/3/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Prince Georges, Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Washington, D.C.</u>				25a. REC'D BY REGISTRAR DATE <u>APR 5 - 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>	



CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Death First Behrmann Middle Behrmann Last Behrmann			2a. DATE OF DEATH Month 3 Day 16 Year 68			2b. HOUR 7:00 M					
3. SEX F		4. RACE W		5. DATE OF BIRTH 3/24/16		6. AGE (In years last birthday) 52 YRS.		IF UNDER 1 YEAR MONTHS 3 DAYS 1		IF UNDER 24 HRS HOURS 7 MINS. 00	
7a. BIRTHPLACE (State or foreign country) WASH, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Co. Md					
10. CITY OR TOWN OF DEATH Silver Spring, Md			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Elizabeth's Nursing Center			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md 13b. COUNTY Montgomery Co. 13c. CITY OR TOWN Silver Spring			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 9320 Daybreak Silver Spring						
14. FATHER'S NAME First Thomas Middle Levy Last Levy			15. MOTHER'S MAIDEN NAME First Sarah Middle Block Last Block								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 57A05-5083		17. INFORMANT Harold Behrmann			Address Same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart attack DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral infarction DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral embolus Cancer of Lung										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min 4 months 6 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Oct 1967 to 3-16-68 , 19____, that (I) (we) last saw the deceased alive on 3-15-68 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Milton Gendek, MD DEGREE MD ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 3/16/68					
22d. PHYSICIAN'S NAME (Type) Milton Gendek, MD						22e. ADDRESS 1106-22 NW Wash DC 3					
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation		23b. DATE 3-16-68		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) COLUMBIA PLANO MD					
24. FUNERAL DIRECTOR Holberg Funeral Home ADDRESS 4817-9th St. N.W. W.				25a. REC'D BY REGISTRAR MAR 19 1968		25b. REGISTRAR'S SIGNATURE Charles J. Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR STATE HEALTH DEPT.

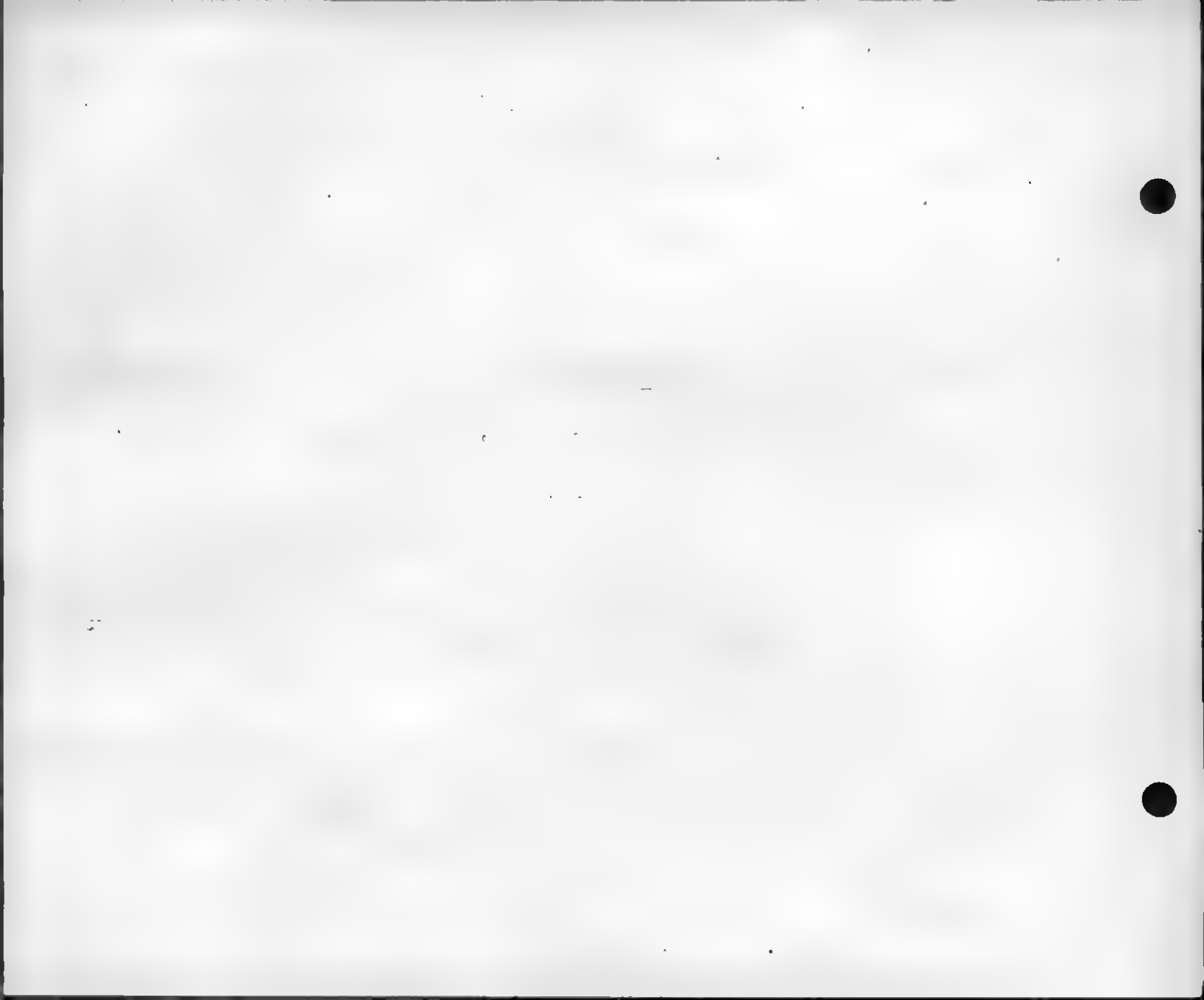
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

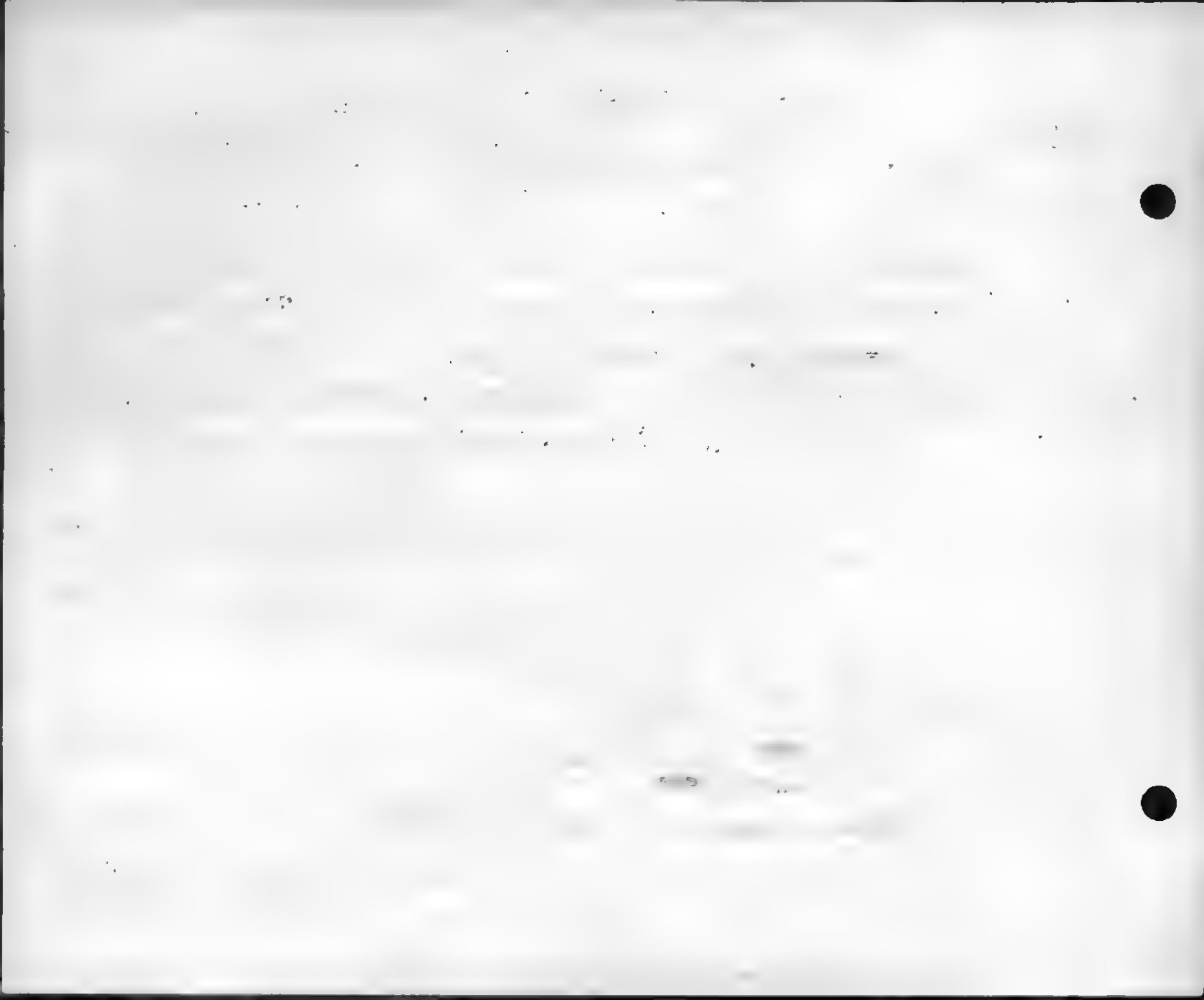
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) <i>First Middle Last</i> <i>John E. Bell</i>						2a. DATE KNOWN OF ESTI-DEATH MATED <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <i>3 15 1968</i>			2b. HOUR <i>5 AM</i>		
3 SEX <i>Male</i>	4 RACE <i>W</i>	5 DATE OF BIRTH <i>6/20/27</i>	6 AGE (in years last birthday) <i>46</i> YRS	7 IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>	8 F UNDER 24 HRS HOURS <i>0</i> MIN <i>0</i>	2c. DATE PRONOUNCED DEAD <i>Month Day Year</i> <i>March 15 1968</i>			2d. HOUR <i>5 PM</i>		
7a. BIRTHPLACE (State or foreign country) <i>Frederick Co.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Mortgomery</i> Md.					
10. CITY OR TOWN OF DEATH <i>Poolesville</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>14 Vermont Circle</i>			12a. USUAL OCCUPAT ON (Kind of work done during most of working life, even if retired.) <i>Teacher</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>State</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>				13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Poolesville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>14 Vermont Circle</i>	
14. FATHER'S NAME <i>First Middle Last</i> <i>David E. Biddinger</i>				15. MOTHER'S MAIDEN NAME <i>First Middle Last</i> <i>Nina Boone</i>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>			
16b. SOCIAL SECURITY NO <i>216-22-0957</i>				17. INFORMANT <i>John Boone Biddinger</i>				ADDRESS <i>Poolesville Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aneurysm Dissecting, Ruptured intra-pericardial</i> <i>441.0</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Years</i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>451.0</i>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>19</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> OR NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John E. Bell</i> EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED <i>3/15/68</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE <i>3-18-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Union Chapel</i>		23d. LOCATION (City or Town) (County) (State) <i>Frederick Co. Md.</i>			
24. FUNERAL DIRECTOR <i>Ernest C. Gartner</i>				ADDRESS <i>Gaithersburg, Md.</i>				25a. REC'D BY REGISTRAR <i>MAR 18 1968</i>		25b. REGISTRAR'S SIGNATURE <i>John E. Bell</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) Barbara (None) Binder						2a. DATE OF DEATH Month March Day 23 Year 1968			2b. HOUR 2:40^{PM}		
3 SEX Female		4 RACE White		5. DATE OF BIRTH May 21, 1936			6. AGE (In years last birthday) 31 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? America		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY 		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Potomac		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1 Greenland Court			
14. FATHER'S NAME First Murray Middle Last Newman				15. MOTHER'S MAIDEN NAME First Celia Middle GRUBMAN Last 							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes no, or unknown <input type="checkbox"/> (If yes give war or dates of service) no				16b. SOCIAL SECURITY NO. 		17. INFORMANT Patient's chart Address 					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Globulostoma multifurcata 1127 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1927											
19a. DATE OF OPERATION 		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month Day Year P.M. 		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) 							
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) 				21f. LOCATION Street or R.F.D. No. City or Town County State 					
22a. I certify that (I) (the hospital) attended the deceased from 3-10, 1968 to 3-22, 1968 that (I) (we) last saw the deceased alive on 3-22, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE G.B. CUSHNER M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 3-23-68					
22d. PHYSICIAN'S NAME (Type) G.B. CUSHNER						22e. ADDRESS 11161 New Hampshire Ave. White Oak Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) 		23b. DATE 3/24/68		23c. NAME OF CEMETERY OR CREMATORY KINGDAVID Mem Garden		23d. LOCATION (City or Town) Falls Church (County) Vol (State) 					
24. FUNERAL DIRECTOR Harold Danyowsky & Sons 3101 14th St. Wash. DC						25a. REC'D BY REGISTRAR DAMAR 26 1968		25b. REGISTRAR'S SIGNATURE 			



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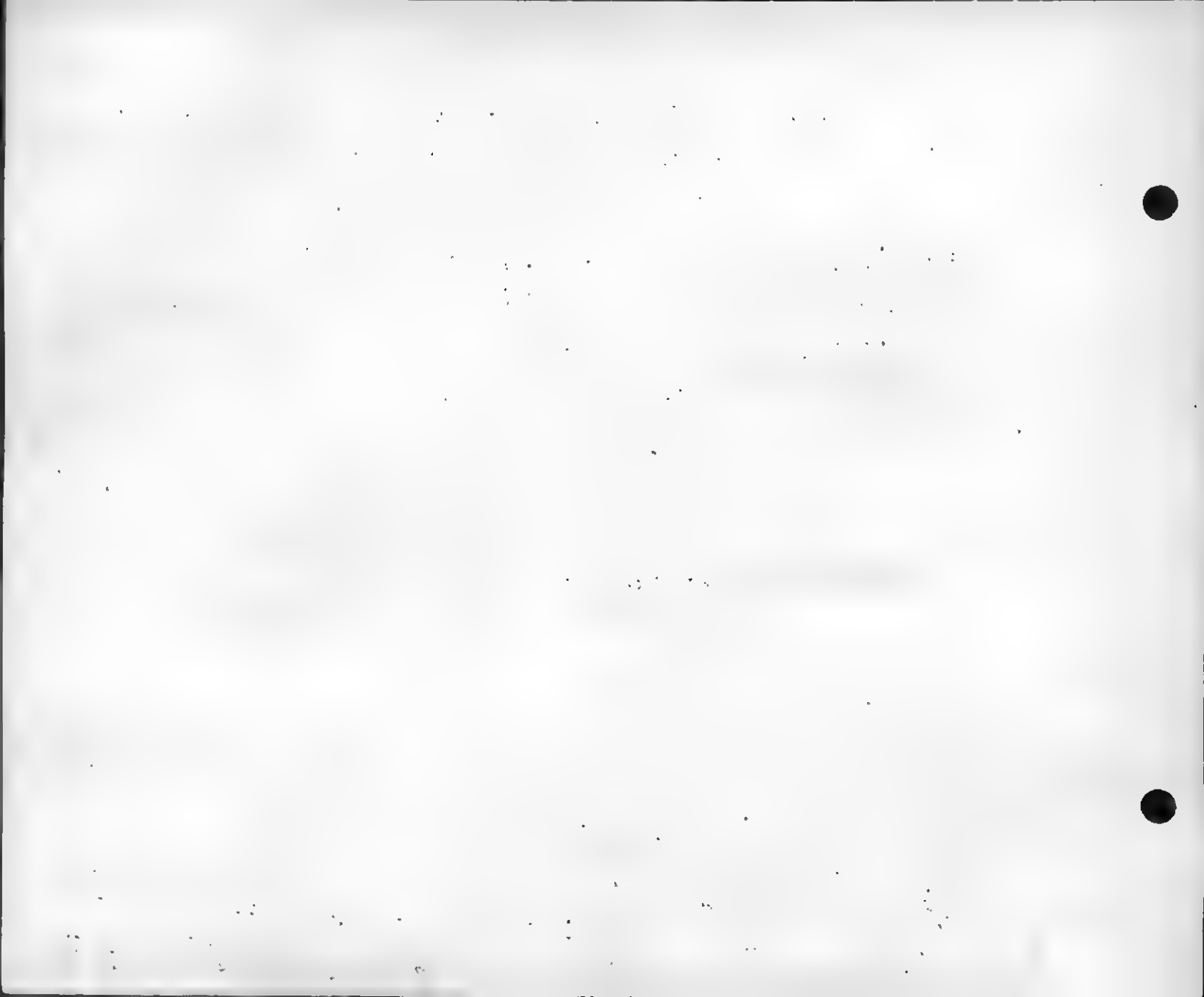
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VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <u>Claude Lockyer Blandford</u>			2a. DATE OF DEATH Month <u>3</u> Day <u>24</u> Year <u>68</u>			2b. HOUR <u>1:19 PM</u>	
3. SEX <u>Male</u>		4. RACE <u>white</u>		5. DATE OF BIRTH <u>3-2-92</u>		6. AGE (In years last birthday) <u>76</u> YRS.	
7a. BIRTHPLACE (State or foreign country) <u>Newfoundland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md	
10. CITY OR TOWN OF DEATH <u>Takoma Park</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Washington Sanatorium & Hospital</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>minister</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Stevensville</u>		13c. CITY OR TOWN <u>Stevensville</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <u>19 Bayside Drive</u>		14. FATHER'S NAME First Middle Last <u>Archibald Blandford</u>		15. MOTHER'S MAIDEN NAME First Middle Last <u>Sarah Lockyer</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <u>No</u>		16b. SOCIAL SECURITY NO <u>012-16-4699</u>		17. INFORMANT <u>Chant</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Ventricular Fibrillation</u> <u>410.1</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Hypertension</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (if either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> , 19 <u>67</u> , to <u>March 24</u> , 19 <u>68</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>March 24</u> , 19 <u>68</u> , and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (did) (did not) view the body after death.							
22b. SIGNATURE <u>R. H. Sandstrom M.D.</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <u>R. H. Sandstrom M.D.</u>				22e. ADDRESS <u>7701 Carroll Ave Takoma Park, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>3-28-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union</u>		23d. LOCATION (City or Town) (County) (State) <u>Montgomery Comm.</u>	
24. FUNERAL DIRECTOR <u>Edgar L. Lane</u>				ADDRESS <u>Church Hill</u>		25a. REC'D BY REGISTRAR <u>MAR 29 1968</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

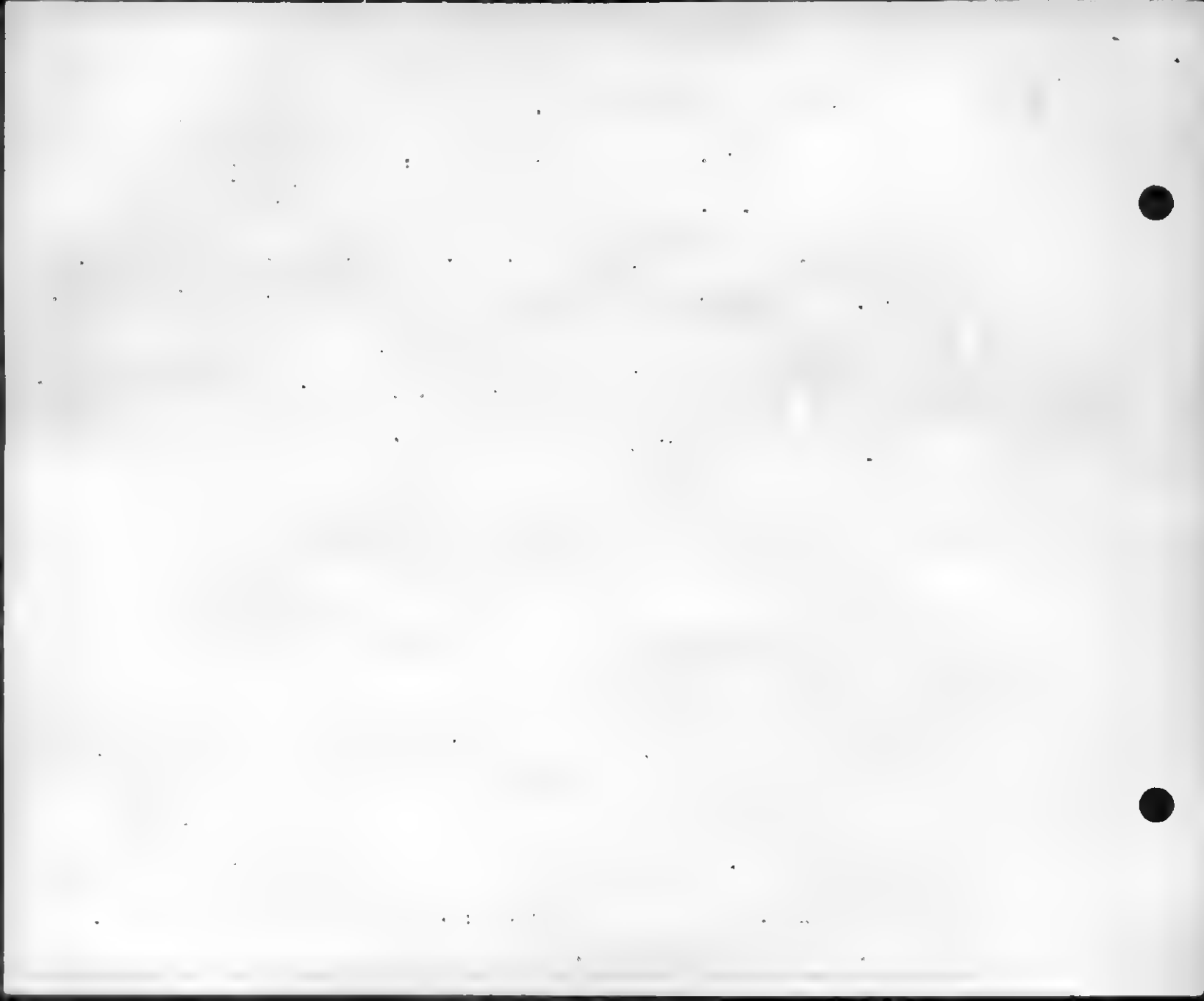


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last CLETA PAULINE BLINKHORN			2a. DATE OF DEATH Month Day Year March 15, 1968		2b. HOUR 6:10AM
3 SEX Female	4 RACE Cauc.	5. DATE OF BIRTH July 19, 1922		6 AGE (In years - last birthday) 45 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Illinois	7b. CITIZEN OF WHAT COUNTRY? U. S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md	
10 CITY OR TOWN OF DEATH Silver Spring,		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Operator-Telephone Co.	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Montgomery	13c. CITY OR TOWN Potomac	13d. INSIDE CITY 1 AM 1 PM YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 11701 Green Lane Dr.
14 FATHER'S NAME First Middle Last Paul Metzger			15. MOTHER'S MAIDEN NAME First Middle Last Cleta Rogers		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO		17 INFORMANT Address Joseph A. Blinkhorn Same as Item 13.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral hemorrhage 431.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 4-25, 1967 , to 3-15, 1968 , that (I) (we) last saw the deceased alive on 3-14, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Ronald L. Bucy		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-15-68	
22d. PHYSICIAN'S NAME (Type) DONALD L. BUCY		22e. ADDRESS 809 Viers Mill Rd. Rockville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-18-68		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.	
23d. LOCATION (City or Town) (County) (State) Silver Spring, Md.					
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		ADDRESS		25a. REC'D BY REGISTRAR DATE MAR 26 1968	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Item 2 Film G399 4/2/68											
CERTIFICATE OF DEATH											
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u> Chevy Chase </u>						c. LENGTH OF STAY IN 1b					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethesda Silver Spring Nursing Home</u>						d. STREET ADDRESS <u>401 Aspen St. NW</u> <u>8700 Jones Mill Rd</u>					
3 NAME OF DECEASED (Type or print) First <u>Rifka</u> Middle <u>-</u> Last <u>Bogner</u>						4. DATE OF DEATH Month <u>March</u> Day <u>23</u> Year <u>1968</u>					
5 SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/21/1880</u>		9 AGE (In years lost birthday) <u>87</u> yrs		10 IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>				10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <u>Poland</u>				12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Karbel Hellmann</u>						14 MOTHER'S MAIDEN NAME <u>Malcha</u>					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown) (If yes give war or dates of service)				16 SOCIAL SECURITY NO		17 INFORMANT <u>Rabbi Arthur Bogner-404 Aspen St. NW.</u>				Address <u>Wash. D.C.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Disseminated Metastases</u> <u>174X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>170X</u> DUE TO (b) <u>Adenocarcinoma of Breast</u> (c)										INTERVAL BETWEEN ONSET AND DEATH <u>many months</u> <u>3 years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis, Meningioma</u>										19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)							
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>67</u> , to <u>3/23</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3/23</u> , 19 <u>68</u> , and that death occurred at <u>9:00</u> M, from causes and on the date stated above.											
22a SIGNATURE <u>G. Leonard Gold</u> M.D.						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED <u>3/23/68</u>			
22c PHYSICIAN'S NAME (Type) <u>DR. G. LEONARD GOLD</u>						22d ADDRESS <u>9801 Georgia Ave. S.E. Md.</u>					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF		23c NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State) <u>15 RAEL</u>			
<u>BURIAL</u>		<u>MAY 27/68</u>									
24. FUNERAL DIRECTOR <u>Bernard Kanyansky & Son</u> ADDRESS <u>Wash. D.C.</u>						25a REC'D BY REGISTRAR DATE <u>MAR 27 1968</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



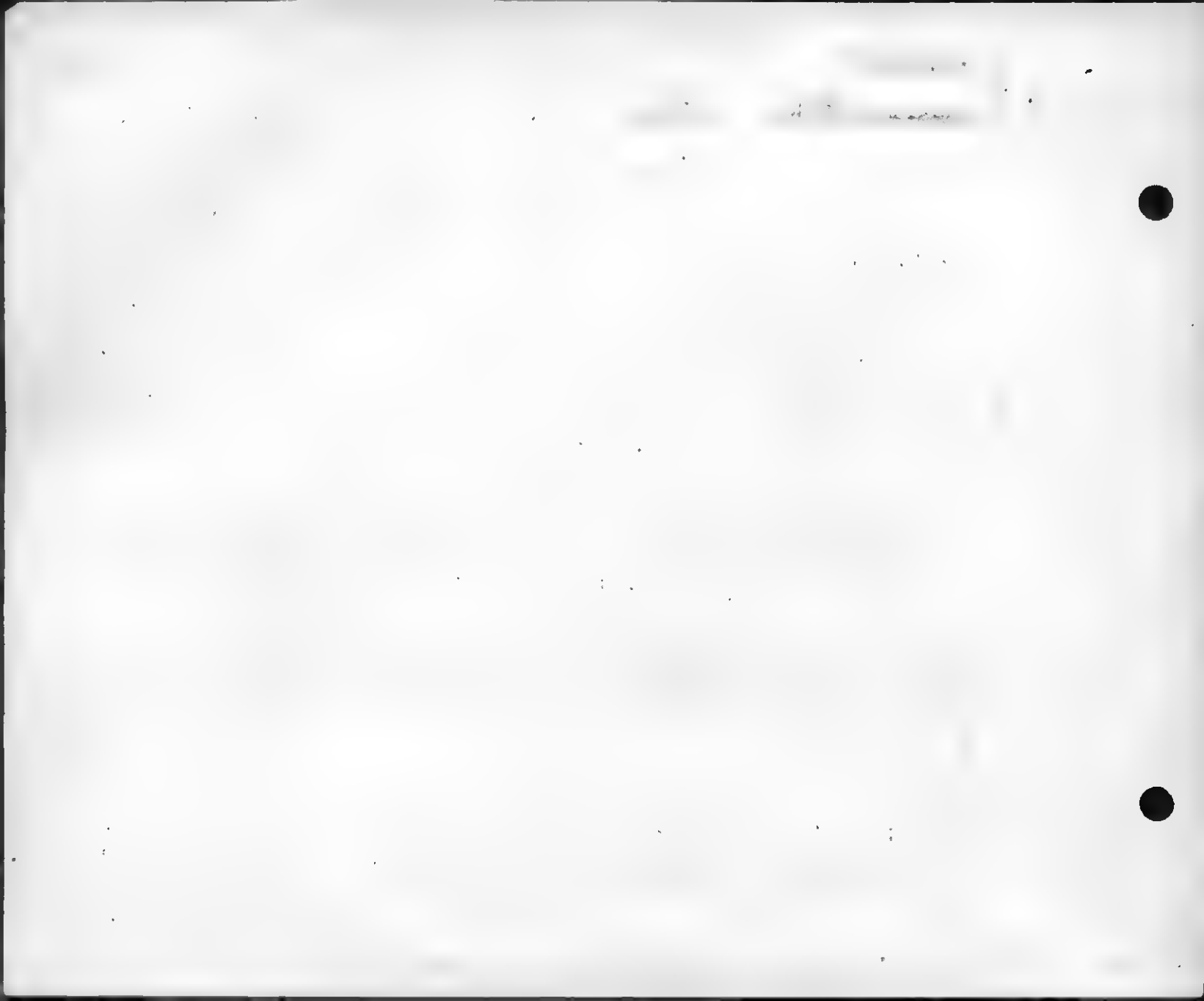
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
30M REV 1-68

MD265
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) ERIC BRIAN BONNER			2a. DATE OF DEATH Month 3 Day 16 Year 68			2b. HOUR 4 PM	
3. SEX Male		4. RACE WHITE		5. DATE OF BIRTH 3-16-68		6. AGE (In years lost birthday) 24 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUBURBAN HOSP		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 901 Wade Ave		14. FATHER'S NAME First Middle Last CURTIS Maxw. H BONNER		15. MOTHER'S MAIDEN NAME First Middle Last Karen Jean Smith			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Father		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EMMA TURITY 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PREMATURE DELIVERY DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Polycystic Kidneys							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE Joseph O'Neil				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/16/68	
22d. PHYSICIAN'S NAME (Type) Joseph O'Neil				22e. ADDRESS 50 W. Edmondston Drive, Rockville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/18/68		23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville Montgomery Md.	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home				ADDRESS 1331 Rock. Pike		25a. REC'D BY REGISTRAR DATE MAR 19 1968	
				25b. REGISTRAR'S SIGNATURE Juanita Judge			
Rockville, Md.							



TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

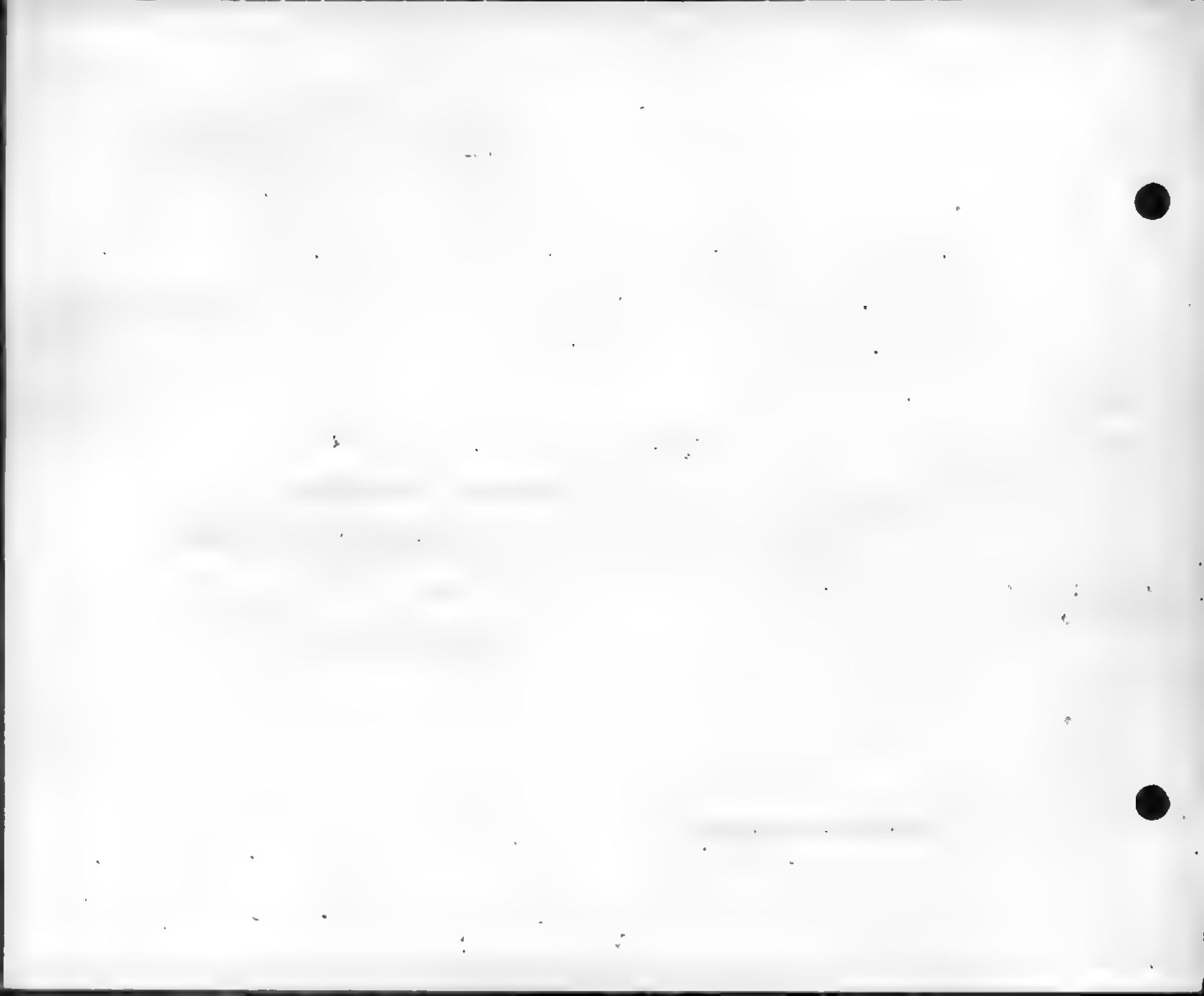
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
304A REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First NELLIE		Middle I.		Last BOXALL		2a. DATE OF DEATH Month 3 Day 18 Year 68			2b. HOUR 10:20	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 10-21-06			6. AGE (In years last birthday) 61 YRS.		7. UNDER 1 YEAR MONTHS 61 DAYS 18		8. UNDER 24 HRS. HOURS 10 MIN 20	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.						
10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MONTGOMERY GENERAL				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED			12b. KIND OF BUSINESS OR INDUSTRY -			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BOYDS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER NONE				
14. FATHER'S NAME First Middle Last CHARLES - DILLEHAY				15. MOTHER'S MAIDEN NAME First Middle Last HERMIE - HEISLER								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT MEDICAL RECORDS Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1829 IMMEDIATE CAUSE (a) <u>Adenocarcinoma of the uterus</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>with wide spread metastases to</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>poisonum and lung and skin</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 174												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Christa L. Runyan</i>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) C. L. WAGSTAFF, M. D.						22e. ADDRESS MEDICAL CENTER, SANDY SPRING, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/20/68		23c. NAME OF CEMETERY OR CREMATORY Boyd's Presbyterian		23d. LOCATION (City or Town) (County) (State) Boyd's Montg. Md.						
24. FUNERAL DIRECTOR Hilton Funeral Home		ADDRESS Barnesville		25a. REC'D BY REGISTRAR Mar 21 1968		25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>						

MEDICAL CERTIFICATION

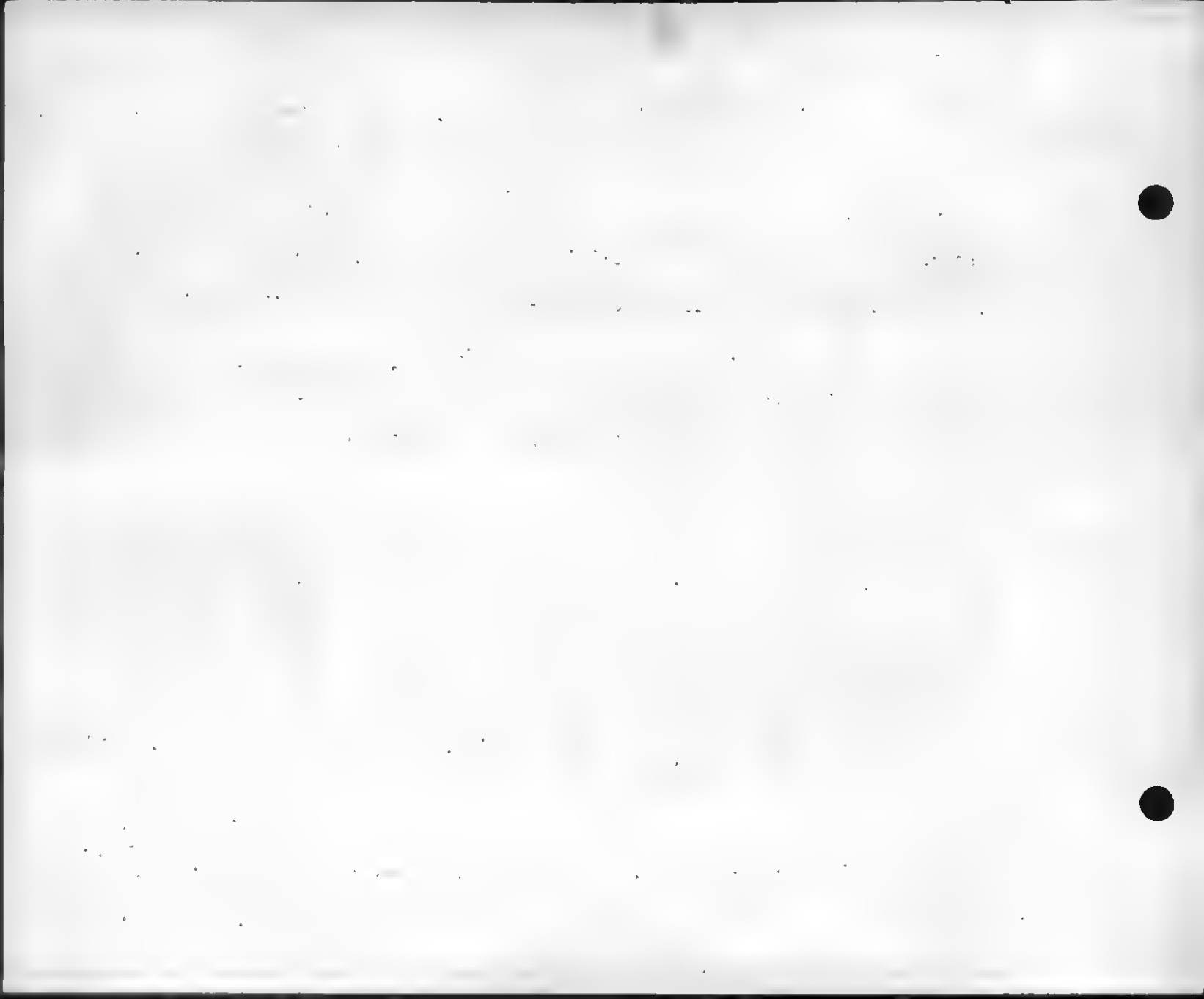


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Clyde Donald Bowers			2a. DATE OF DEATH Month March Day 13 Year 1968		2b. HOUR 6:40 AM <input checked="" type="checkbox"/> PM <input type="checkbox"/>
3. SEX Male	4. RACE White	5. DATE OF BIRTH 6 October 1928		6. AGE (In years last birthday) 39 YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN <input type="checkbox"/>
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Clinical Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Asst. Manager	12b. KIND OF BUSINESS OR INDUSTRY Food Store	
13a. USUA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY & M.T.S? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 17 E. 4th Street	
14. FATHER'S NAME First Roy Middle C. Last Bowers		15. MOTHER'S MAIDEN NAME First Cora Middle Bell Last Green			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes 1950-52		16b. SOCIAL SECURITY NO. 216-22-9100		17. INFORMANT The Medical Records Address The Clinical Center, Bethesda, Maryland 20014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Histiocytic Medullary Reticulosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Streptococcal Septicemia, Pancytopenia, Subarachnoid Bleeding.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 20 Feb. , 19 68 , to 13 March , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 13 March , 19 68 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Michael Emmer</i> M.D. DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>				22c. DATE SIGNED 13 March 1968	
22d. PHYSICIAN'S NAME (Type) Michael Emmer, M.D.		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 3/16/68	23c. NAME OF CEMETERY OR CREMATORY CEDAR LAWN MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD.	
24. FUNERAL DIRECTOR <i>Nelson L. Eichler</i>		ADDRESS ROUZER FUNERAL HOME HAGERSTOWN, MARYLAND.		25a. REC'D BY REGISTRAR MAR 15 1968	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

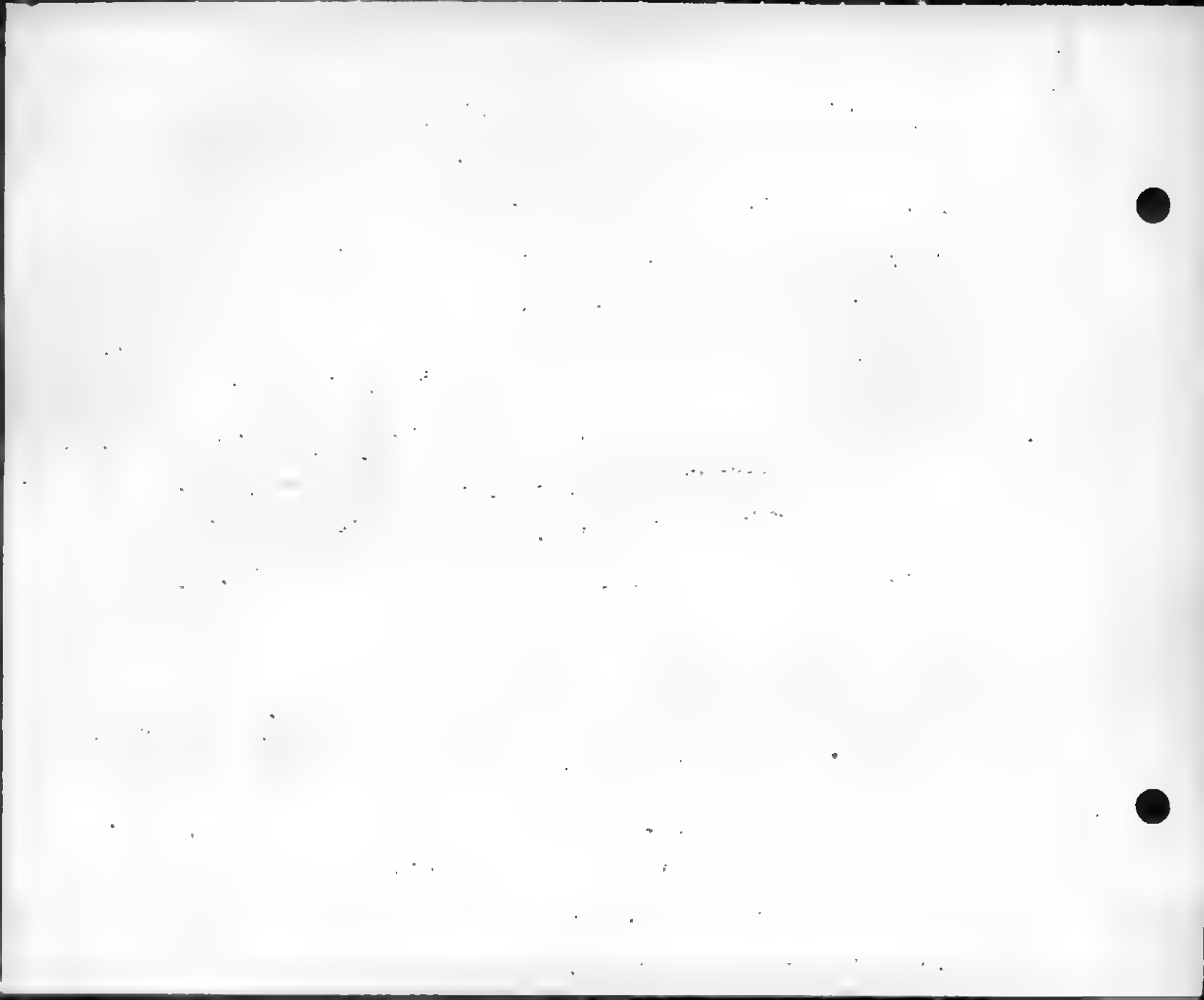


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VR A15 (4)
304 REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) JOHN			First W Middle BOWLER Last			2a. DATE OF DEATH 3 Month 23 Day 68 Year			2b. HOUR 3:00am
3. SEX Male		4. RACE White		5. DATE OF BIRTH 4/29/82		6. AGE (In years last birthday) 85 YRS.		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Olney			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Plumber		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Prince Georges		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 6408 40th Avenue
14. FATHER'S NAME First JOHN Middle BOWLER Last			15. MOTHER'S MAIDEN NAME First Mary Middle Laimer Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT Medical Records Address Montgomery General Hospital Olney, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY CONGESTION 2509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last CEREBRAL ANEMIA-DIFFUSE MONTHS (b) PULMONARY EMPHYSEMA (c) YRS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH TERMINAL									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DIABETES MELLITUS - PEPTIC ULCER									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 3/10 , 19 68 , to 3/23 , 19 68 , that (I) (we) last saw the deceased alive on 3/23 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Donald R. Lewis MD DEGREE MD					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 23 Mar 68		
22d. PHYSICIAN'S NAME (Type) Donald R. Lewis, MD					22e. ADDRESS 700 Cloverly, Silver Spring, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3/25/68		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor, Maryland			
24. FUNERAL DIRECTOR F. Gasch's Sons ADDRESS Hyattsville, Maryland					25a. REC'D BY REGISTRAR MAR 26 1968		25b. REGISTRAR'S SIGNATURE [Signature]		

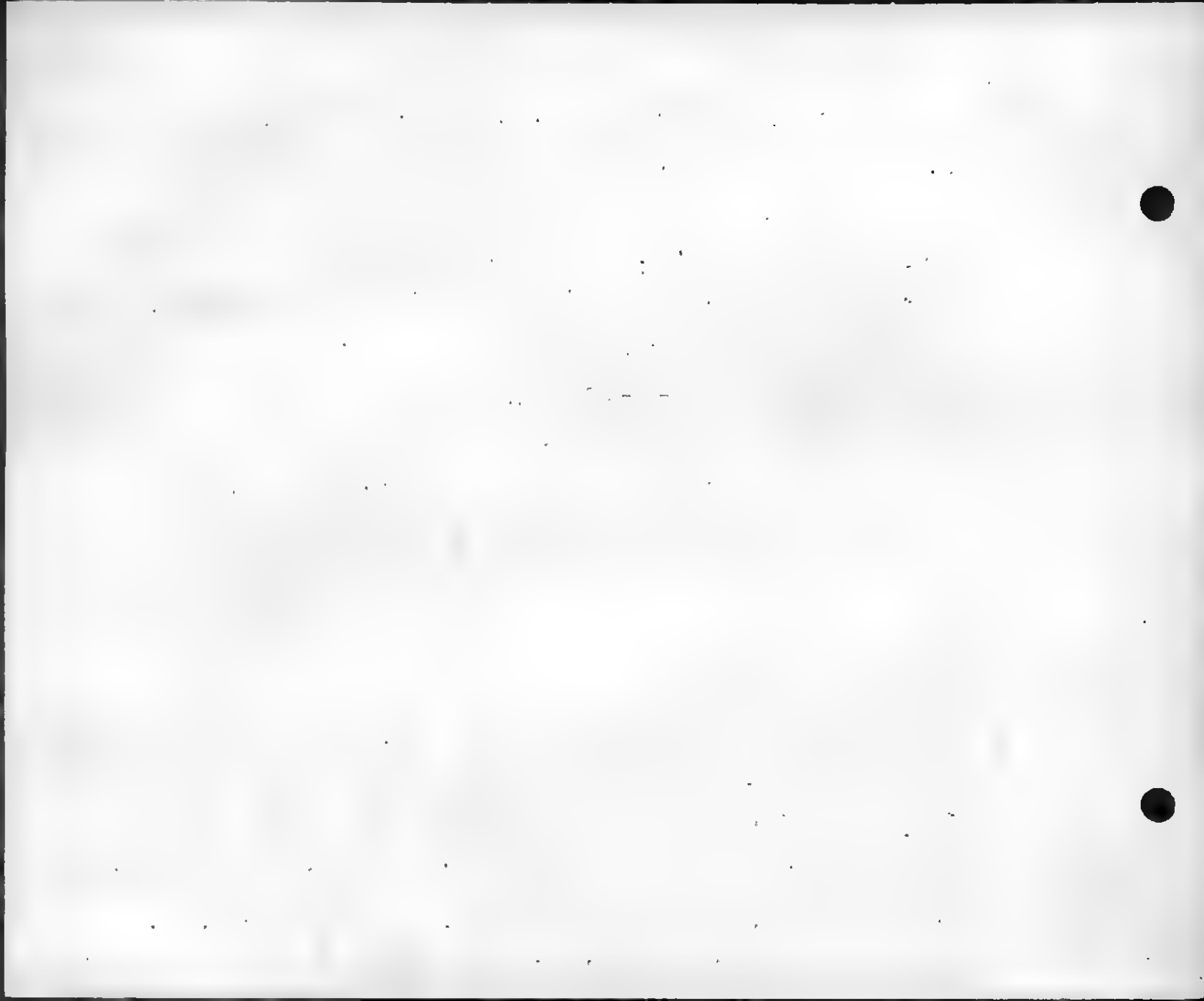


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5426. 253
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Katherine Elizabeth Brandenburg			2a. DATE OF DEATH Month 3 Day 1 Year 68			2b. HOUR 10 AM				
3 SEX Female		4 RACE White		5 DATE OF BIRTH 5-2-95		6. AGE (In years lost birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS M.N.		
7a. BIRTHPLACE (State or foreign country) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md				
10 CITY OR TOWN OF DEATH Takoma Park			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San. & Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Hsuf			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md			13b. COUNTY PG		13c. CITY OR TOWN Adelphi		13d. INSIDE CITY L.A.M.T? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1921 Saratoga Dr	
14. FATHER'S NAME First Middle Last Downey Williams			15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Bolton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no			16b. SOCIAL SECURITY NO (If yes give war or dates of service) 223-38-1818		17 INFORMANT Hospital Record				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage 431.4 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease. DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from Jan, 1967, to 3-1, 1968, that (I) (we) last saw the deceased alive on 3-1 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Morton Altschuler						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 3-1-68		
22d. PHYSICIAN'S NAME (Type) Morton Altschuler, M.D.						22e. ADDRESS 5205 New Hange Ave. Suit 507				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Mar. 4, 1968		23c. NAME OF CEMETERY OR CREMATORY Providence Meth.		23d. LOCATION (City or Town) Kemptown, Md.		(County) (State)		
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.						25a. REC'D BY REGISTRAR DATE MAR 6 1968		25b. REGISTRAR'S SIGNATURE John L. Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <i>Mary F. Brown</i>			2a. DATE OF DEATH Month <i>3</i> Day <i>14</i> Year <i>68</i>			2b. HOUR <i>6:40</i> a.m.			
3. SEX <i>Female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>10/11/92</i>		6. AGE (In years last birthday) <i>74</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross Hosp</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Non home</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>10704 Inwood Ave.</i>	
14. FATHER'S NAME First <i>Patrick</i> Middle <i>McLaughlin</i> Last <i>McLaughlin</i>			15. MOTHER'S MAIDEN NAME First <i>Ellen</i> Middle <i>Moss</i> Last <i>Moss</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>		16b. SOCIAL SECURITY NO. <i>yes</i>		17. INFORMANT <i>Mr. John J. Brown 10716 Georgia Ave. Adelphi, Maryland</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> <i>411X</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cor pulmonale</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic bronchitis & emphysema</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Generalized Arteriosclerosis</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 years</i> <i>5 years</i> <i>years</i>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov 1, 1967</i> to <i>Mar 4, 1968</i> , that (I) (we) last saw the deceased alive on <i>3/14/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE <i>John J. Curry</i>								22c. DATE SIGNED <i>3/14/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>John J. Curry</i>		22e. ADDRESS <i>9801 Georgia Ave Silver Spring</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>March 16, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glenwood Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Washington, D.C.</i>			
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>		24b. ADDRESS <i>C. Glen Carter 8434 Georgia Ave. Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR <i>DATE MAR 18 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The  requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30A REV 1/68

52263
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <i>Brooy</i>		First Middle Last <i>Brooy</i>		2a. DATE OF DEATH <i>3</i> Month <i>29</i> Day <i>68</i> Year		2b. HOUR <i>6:58</i> PM	
3 SEX <i>Female</i>		4. RACE <i>white</i>		5 DATE OF BIRTH <i>3/29/68</i>		6 AGE (In years last birthday) YRS. MONTHS DAYS <i>2</i> <i>0</i> <i>0</i>	
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross Hosp</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Beltsville</i>		13c CITY OR TOWN <i>Beltsville</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Middle Last <i>LARRY Duwain Brooy</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Kathleen Hope Hillock</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT <i>mother</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Prematurity</i> <i>777X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State <i>4000 Univ. Blvd. Silver Spring, Md.</i>			
22a. I certify that (I) (this hospital) attended the deceased from <i>3/24</i> , 19 <i>68</i> , to <i>3/29</i> , 19 <i>68</i> , that (I) (we) lost the deceased alive on <i>3/29</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Murray Paul</i> MD				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <i>4/4/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Murray Paul</i>				22e. ADDRESS <i>1040 Univ. Blvd. Silver Spring, Md.</i>			
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>4/10/68</i>		23c NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Silver Spring, Maryland</i>	
24 FUNERAL DIRECTOR <i>Lynon Wheeler</i>		1331 Rockville Pike <i>Rockville, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>APR 11 1968</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

4/4/08

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH ESTIMATED				2b. HOUR			
Grayson		B.		Burnell		Month Day Year 3 20 1968				8:40 P.M.					
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD		2d. HOUR			
M.	N.	April 21, 1997		70 YRS						Month Day Year March 20 1968		8:40 P.M.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH									
Maryland		U.S.A.				Montgomery				Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USJA. OCCUPATION (Kind of work done during most of working life, even if retired)				2b. KIND OF BUSINESS OR INDUSTRY					
Germantown.		R.F.D. I				Land Scaping				Nurseryman					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER							
Maryland		Montgomery		Germantown				R.F.D. #1.							
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last	
Robert						Bunnell		Gertie						Baker	
6a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
NO.		212-14-8643		Mrs Myrtle Leah Burnell, Germantown, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency Acute.												Sudden.			
411.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
(b) DUE TO, OR AS A CONSEQUENCE OF															
(c) DUE TO, OR AS A CONSEQUENCE OF															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
4201															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				John G. Ball				M.D.				22b. DATE SIGNED			
EXAMINER'S NAME (Type)				John G. Ball, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, City, State, and Zip)			
								Baltimore, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
Burial				March 23, 1968		Upper Seneca Baptist				Cedar Grove, Md.					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Olin L. Molesworth, Damascus, Md.								MAR 26 1968				[Signature]			



FOR STATE HEALTH DEPT.

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VR A15ME (5)
10M REV 1/68

04271

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11251

1 DECEASED NAME (Type or Print) Edward Minor Burns			2a DATE KNOWN OF DEATH MARCH 4 1968			2b HOUR 3:30 AM		
3 SEX MALE	4 RACE white	5 DATE OF BIRTH 11-9-06	6 AGE (in years last birthday) 65 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD MARCH 4 1968		2d HOUR 3:30 AM
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md		
10 CITY OR TOWN OF DEATH BETHESDA		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) FARMER		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution) STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Montgomery		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER Rt #1 Ex 83
14 FATHER'S NAME NICHOLAS E BURNS			15 MOTHER'S MAIDEN NAME Laura Gertrude King					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b SOCIAL SECURITY NO 218-12-6435		17 INFORMANT RUTH BURNS - WIFE				
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary insufficiency DUE TO, OR AS A CONSEQUENCE OF (b) due to severe emphysema, bilateral DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 527.1								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County State
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE John G. Ball			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED March 4, 1968		
EXAMINER'S NAME (Type) John G. Ball, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
ADDRESS (Street, city, town, or county) Bethesda, Md.								
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE Mar. 6, 1968		23c NAME OF CEMETERY OR CREMATORY Mt. View		23d LOCATION (City or Town) (County) (State) Purdim, Md.		
24 FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.				25a REC'D BY REGISTRAR DATE MAR 8 1968		25b REGISTRAR'S SIGNATURE Charles Judge		

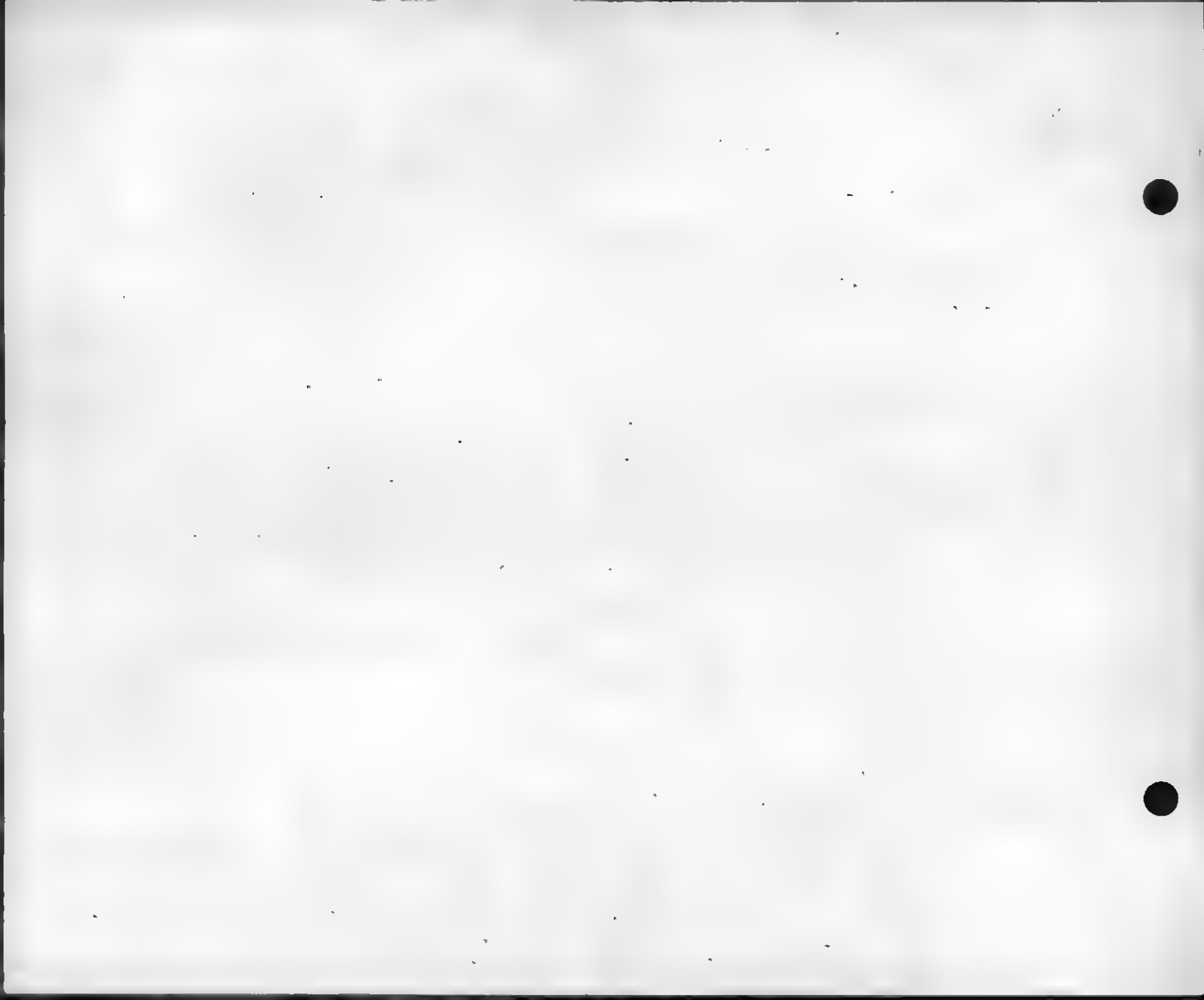


FOR STATE HEALTH DEPT.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First JOHN			M. date FRANKLIN			Last BURRISS		
2a. DATE KNOWN OF ESTI DEATH MATED		Month 3		Day 28		Year 1968		2b. HOUR 8:35		M AM	
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH 4-1-20		6 AGE (In years last birthday) 47 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN 0	
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH MONTGOMERY		
10. CITY OR TOWN OF DEATH OLNEY			11. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address) DOA MONTGOMERY GENERAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) BRICK LAYER			12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND			13b. COUNTY MONTGOMERY			13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER 1625 BONIFANT ROAD	
14. FATHER'S NAME First FRED Middle G. Last BURRISS			15. MOTHER'S MAIDEN NAME First VIRGIE Middle - Last TURNER								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES			16b. SOCIAL SECURITY NO (If yes give war or dates of service)			17. INFORMANT MEDICAL RECORD DEPT.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hypertension 1-2 days											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) Coronary Occlusions old multiple years											
(c) Cerebrovascular Cardiovascular Disease											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Hypertensive Cardiovascular Disease											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Beloen R. Reap			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 3/28/1968		
EXAMINER'S NAME (Type) BELOEN R. REAP M.D.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, county)		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE April 1, 1968			23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery			23d. LOCATION (City or Town) (County) (State) Prince Georges Co. Md.		
23e. FUNERAL DIRECTOR John Carter			ADDRESS 1024 Silver Spring, Md.			23f. REC'D BY REGISTRAR APR 3 - 1968			23g. REGISTRAR'S SIGNATURE John Carter		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print) First Middle Last John Callahan Burton			2a. DATE OF DEATH Month Day Year MAR. 8 1968			2b. HOUR 3:30 A M	
3 SEX male		4 RACE white		5. DATE OF BIRTH 10-28-05		6. AGE (in years last birthday) 62 YRS	
7a. BIRTHPLACE (State or foreign country) Indiana		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Civil Engineer		12b. KIND OF BUSINESS OR INDUSTRY U S Air Force	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 5010 Delray Ave		14. FATHER'S NAME First Middle Last Edward Burton		15. MOTHER'S M.A.D.E.N NAME First Middle Last Callahan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO		17. INFORMANT Address Helen M. Burton wife - add. same.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RIGHT VENTRICULAR FAILURE 211X DUE TO, OR AS A CONSEQUENCE OF (b) SEVERE HYPOVENTILATION LUNGS DUE TO, OR AS A CONSEQUENCE OF (c) PICKWICK SYNDROME, OBESITY APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 DAYS 1 YEAR							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) CORONARY ATHEROSCLEROSIS							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from DEC. 24, 1944, to MAR 8, 1968, that (I) (we) last saw the deceased alive on 7 MARCH 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert G. Angle M.D.				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-8-68	
22d. PHYSICIAN'S NAME (Type) ROBERT G. ANGLE				22e. ADDRESS 5009 Del Ray Ave. Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-11-68		23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR ADDRESS ROBERT A. PUMPHREY, Bethesda, Maryland				25a. REC'D BY REGISTRAR DATE MAR 14 1968		25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and return them to the funeral director, and in any event, within 22 hours after death should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print) Minnie			First Anne			Middle BUTLER			Last			2a. DATE OF DEATH March 19 Day 1968			2b. HOUR 9:25 ^{PM}		
3. SEX Female			4. RACE Caucasian			5. DATE OF BIRTH Oct. 2, 1889			6. AGE (In years lost birthday) 78 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Louisa, Virginia			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery			Md					
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY N/A								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Prince George			13c. CITY OR TOWN Beltsville			13d. INSIDE CITY LIM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			13e. STREET AND NUMBER 11463 Cherry Hill Rd.					
14. FATHER'S NAME First Denton			Middle Denton			Last Denton			15. MOTHER'S MAIDEN NAME First Perry			Middle Perry			Last Perry		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Apt. 202 Beltsville, Md. DTC Evelyn M. O'Brien, 11463 Cherry Hill Rd.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metabolic imbalance</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic & acute pulmonary failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>3 wks</u> <u>25 yrs</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (A) (this hospital) attended the deceased from <u>Feb. 23</u> , 19 <u>68</u> , to <u>Mar. 19</u> , 19 <u>68</u> , that (A) (we) last saw the deceased alive on <u>March 19</u> , 19 <u>68</u> , and that in (A) (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>C. S. Crummy, M.D.</u>			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED Mar. 20, 1968								
22d. PHYSICIAN'S NAME (Type) C. S. CRUMMY, M.D.			22e. ADDRESS Naval Hospital, Bethesda, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL			23b. DATE 3/20/68			23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery			23d. LOCATION (City or Town) (County) (State) Louisa Virginia								
24. FUNERAL DIRECTOR S. H. Hines Co.			ADDRESS 2901 14th St., N.W. Washington, D. C.			25a. REC'D BY REGISTRAR DATE MAR 21 1968			25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) University Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D.C. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington, D.C. d. STREET ADDRESS 1323 Hemlock St. N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Merle First Middle Last Cain		4. DATE OF DEATH March 25 1968 Month Day Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/20/82 9. AGE (In years last birthday) 85 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph P. Cain	
14. MOTHER'S MAIDEN NAME Sarah Jane McCain		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (Yes, no, or unknown)	
16. SOCIAL SECURITY NO. 577-05-3687		17. INFORMANT J. David Raab-1475 Waggaman Circle Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis Massive 4389 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, 30 DUE TO (b) Cerebral Arterio-sclerosis DUE TO (c) Broncho-pneumonia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Peripheral Arterio-sclerosis - Amputation both lower extremities Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH 48 hrs Undetermined 48 hrs	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 1, 1953 , to Mar 25, 1968 , that (I) (we) last saw the deceased alive on Mar 24, 1968 , and that death occurred at PM , from the causes and on the date stated above.			
22a. SIGNATURE George L. Ball		22b. DATE SIGNED Mar 25, 1968	
22c. PHYSICIAN'S NAME (Type) George L. Ball		22d. ADDRESS 10020 Georgia Ave Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 3/28/68	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Mausoleum	23d. LOCATION (City, town or county) (State) Suitland, Md.
24. FUNERAL DIRECTOR S.H. Hines Co.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAR 27 1968	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <i>Marie</i>			First <i>Marie</i> Middle <i>M.</i> Last <i>Card</i>			2a. DATE OF DEATH Month <i>March</i> Day <i>21</i> Year <i>1968</i>			2b. HOUR <i>9:00 P.M.</i>								
3. SEX <i>Female</i>			4. RACE <i>White</i>			5. DATE OF BIRTH <i>Sept. 15, 1887</i>			6. AGE (In years last birthday) <i>81</i> YRS.			IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i> HOURS <i>0</i> MIN			IF UNDER 24 HRS HOURS <i>0</i> MIN		
7a. BIRTHPLACE (State or foreign country) <i>Poughkeepsie, N.Y.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i> Md								
10. CITY OR TOWN OF DEATH <i>Silver Spring, Md.</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>8811 Colesville Road</i>			12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) <i>Government Clerk (ret)</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>same</i>								
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Montgomery</i>			13b. COUNTY <i>Montgomery</i>			13c. CITY OR TOWN <i>Silver Spr.</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <i>8811 Colesville Road</i>					
14. FATHER'S NAME First <i>Frank</i> Middle <i>Rieser</i> Last <i>Rieser</i>			15. MOTHER'S MAIDEN NAME First <i>Pauline</i> Middle <i>Gillerheimer</i> Last <i>Gillerheimer</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <i>no</i> , or unknown <i>no</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <i>578-26-5576</i>			17. INFORMANT <i>Mrs. Etta Rieser (sister)</i> Address					
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Thrombosis with Infarction</i> <i>410.9</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>												PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Senility</i>					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. _____ P.M. _____ Month _____ Day _____ Year <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____											
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan. 15, 1957</i> , to <i>March 21, 1968</i> , that (I) (we) last saw the deceased alive on <i>March 21, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <i>9:00 A.M.</i>																	
22b. SIGNATURE <i>Philip E. Jones M.D.</i> DEGREE _____ ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>												22c. DATE SIGNED <i>3/21/68</i>					
22d. PHYSICIAN'S NAME (Type) <i>Philip E. Jones M.D.</i>						22e. ADDRESS <i>800 Pershing Dr., Silver Spring, Md.</i>											
23a. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>			23b. DATE <i>March 23, 1968</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Silver Spring, City, Md.</i>								
24. FUNERAL DIRECTOR <i>Clark E. Wisor</i> <i>Warner E. Pumphrey, Inc.,</i>						25a. DATE BY REGISTRAR <i>MAR 27 1968</i>			25b. REGISTRAR'S SIGNATURE <i>John C. Judge</i>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared by Medical Examiner

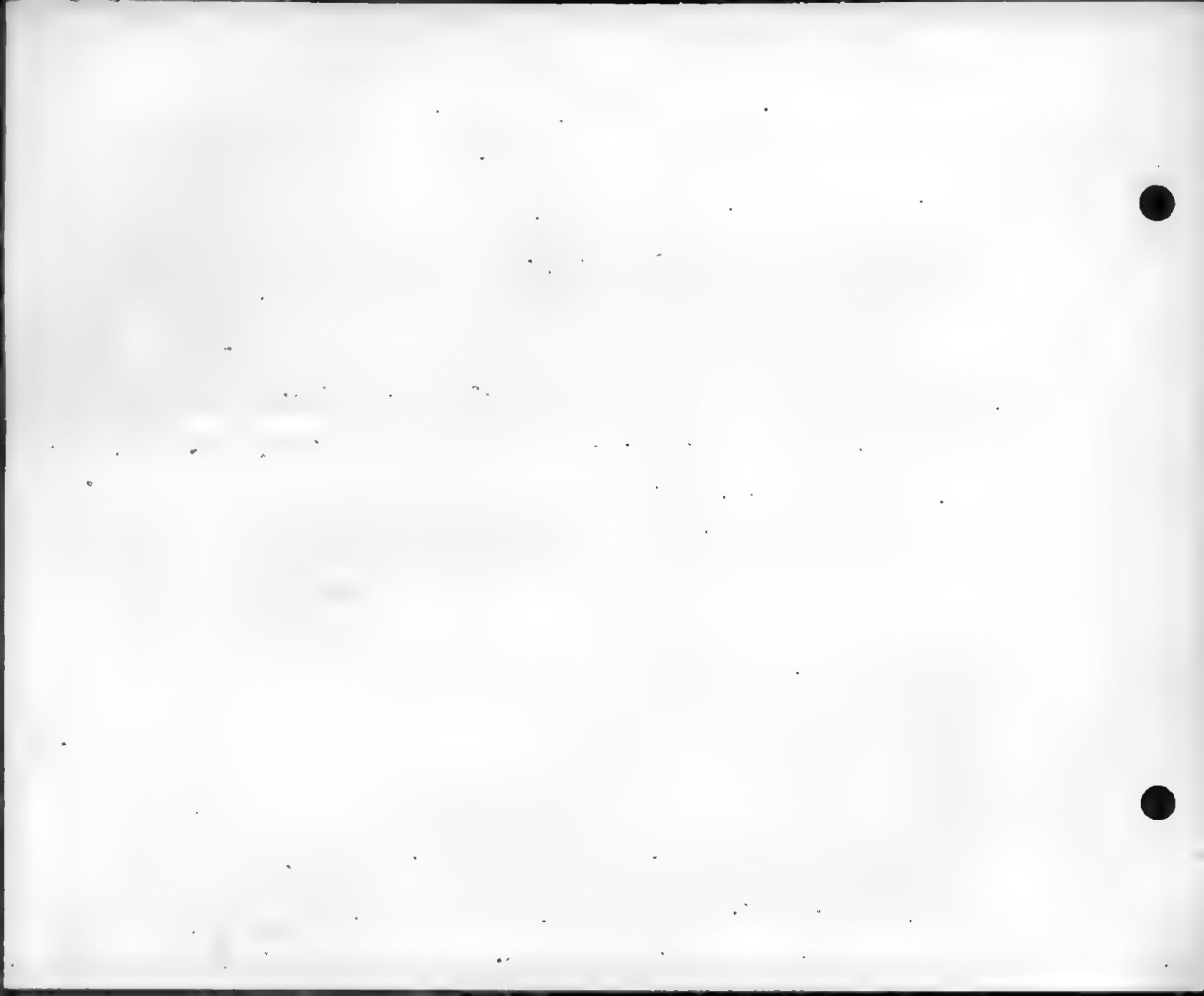


TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD 27
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last BERTHA ELIZABETH CARTER			2a. DATE OF DEATH Month Day Year 3 28 68			2b. HOUR 9 A. M.	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 11-22-07		6. AGE (In years lost birthday) 60 YRS.	
7a. BIRTHPLACE (State or foreign country) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md	
10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MONTGOMERY GENERAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY NAVY DEPT.	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND		13b. COUNTY HOWARD		13c. CITY OR TOWN DAYTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last LOUIS J. LONG		15. MOTHER'S MAIDEN NAME First Middle Last CORA - JOHNSON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT MEDICAL RECORDS DEPT.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Peritonitis and Abscess formation</u> DUE TO, OR AS A CONSEQUENCE OF <u>Colostomy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>5 weeks</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Inoperable Carcinoma of Rectum -</u> <u>1 year?</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>1542</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>3/8</u> , 19 <u>64</u> , to <u>3/28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/28</u> 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Charles S. Whitaker, M.D.</u>				22c. DATE SIGNED <u>3/29/67</u>		22d. PHYSICIAN'S NAME (Type) CHARLES S. WHITAKER, M. D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>4-1-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT VIEW</u>		23d. LOCATION (City or Town) (County) (State) <u>BALPHA HOWARD Md</u>	
24. FUNERAL DIRECTOR <u>Hyacinthia Slack</u>				25a. REGISTERED DATE <u>Ellicott City, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>	

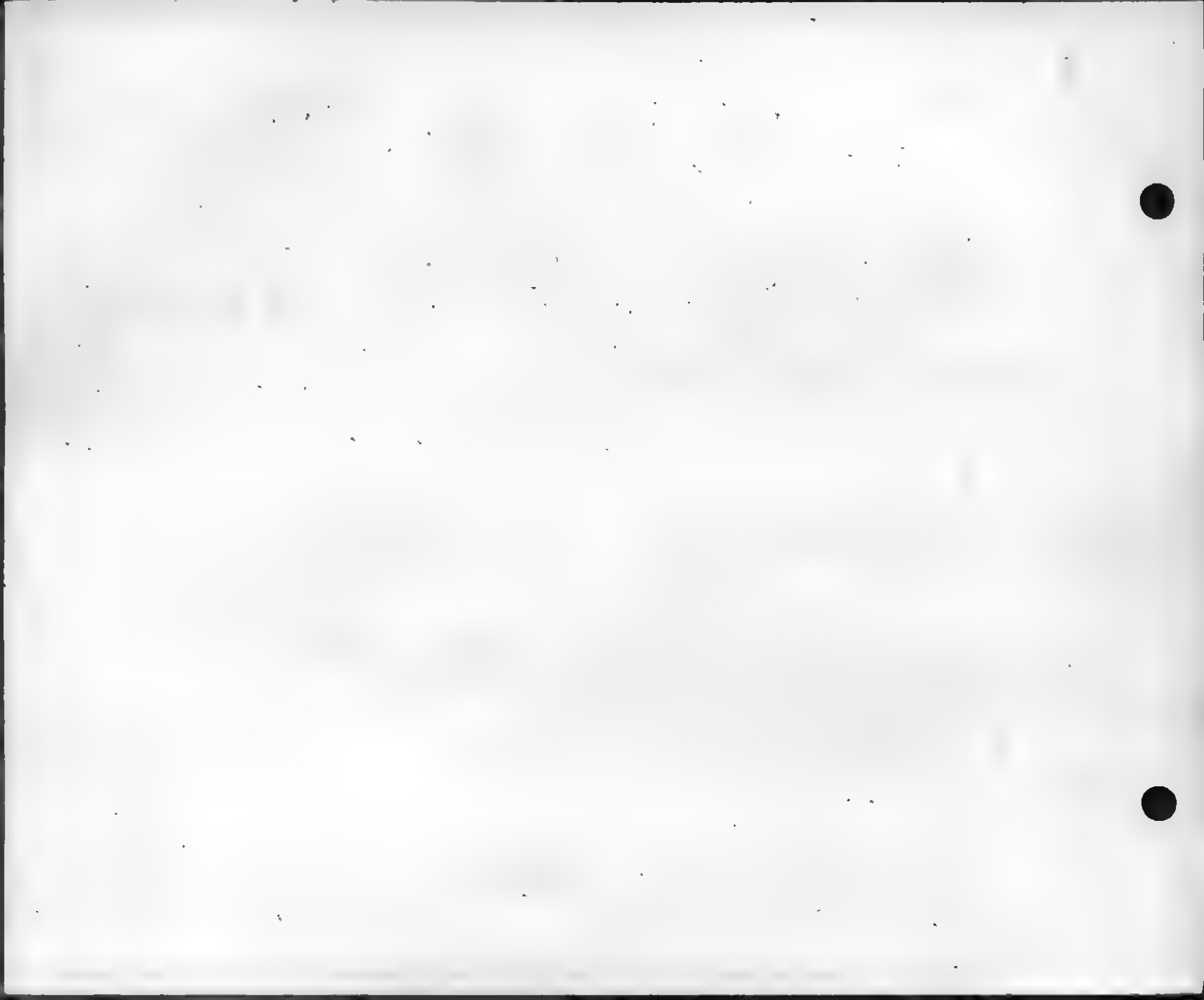


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Samuel I. Chaney			2a. DATE OF DEATH MARCH 23, 1968			2b. HOUR 1:15 AM	
3. SEX Male	4. RACE WHITE	5. DATE OF BIRTH July 17, 1893			6. AGE (In years last birthday) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Holy Cross Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Merchandise		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. CITY OR TOWN Montgomery Kensington		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4404 Dana Ct.	
14. FATHER'S NAME First Middle Last SAMUEL B. CHANEY			15. MOTHER'S MAIDEN NAME First Middle Last MARY L. WOOD				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO 578-26-1755		17. INFORMANT MARGARET C. GEORGE (SAME AS #13) Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon 1538 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med. cert. examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from January, 1967 , to March 23, 1968 , that (I) (we) last saw the deceased alive on March 22, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature] DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 3/23/1968			
22d. PHYSICIAN'S NAME (Type) BLAINE H. EIG				22e. ADDRESS 9801 Georgia Circle, Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3-27-68		23c. NAME OF CEMETERY OR CREMATORY SACRED HEART		23d. LOCATION (City or Town) (County) (State) WHITE MARSH, PR. GEO. MD.	
24. FUNERAL DIRECTOR F.J. COLLINS 3821-14th ST. N.W. D.C.				25a. REC'D BY REGISTRAR WASH.		25b. REGISTRAR'S SIGNATURE [Signature]	
				DATE MAR 26 1968			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the hospital director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 544
30M REV. 3-68

MEDICAL CERTIFICATION

1 DECEASED-NAME (Type or print) ALTON BURTON CISSEL			2a. DATE OF DEATH Month March Day 26 Year 1968			2b. HOUR 5:03 A.M.	
3 SEX MALE		4. RACE White		5. DATE OF BIRTH MARCH 3, 1905		6 AGE (In years lost birthday) 63 YRS.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10 CITY OR TOWN OF DEATH TAKOMA PARK		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington-Sa. W. Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Vice Pres. Columbia Works		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 10231 Riggs Road		14 FATHER'S NAME First Middle Last William P. Cissel		15 MOTHER'S MAIDEN NAME First Middle Last Ida KANOK			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes no, or (unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 578-03-1944		17. INFORMANT Hospital Record Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute pulmonary edema (cardiovas. collapse) 4127 DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 mins 10 yrs.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from August 1, 1964 , to MARCH 26, 1968 , that (I) (we) last saw the deceased alive on MARCH 21, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert A. McCormick MD				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/26/68	
22d. PHYSICIAN'S NAME (Type) Robert A. McCormick				22e. ADDRESS 4316 Clagett Rd. Hyattsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 29 MAR 1968		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM		23d. LOCATION (City or Town) (County) (State) COLMAR MANOR, MD	
24. FUNERAL DIRECTOR W.W. Chambers Co		ADDRESS Riversdale, Md.		25a. REC'D BY REGISTRAR APR 1 - 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

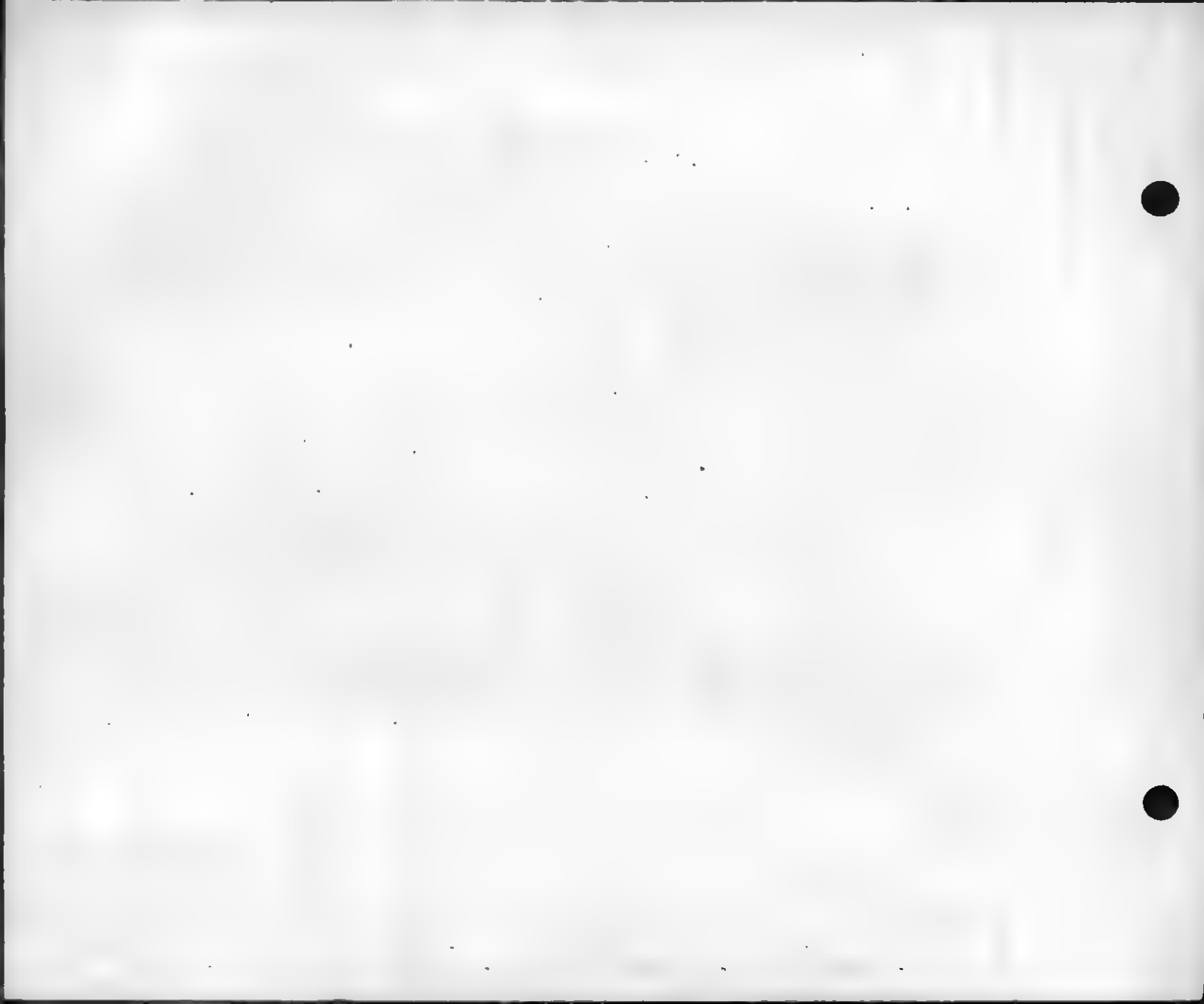
1. DECEASED-NAME (Type or print) <i>Mary C. Conley</i>			2a. DATE OF DEATH 3 Month 22 Day 68 Year			2b. HOUR 10 ¹⁵ P. M.					
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>11-28-95</i>		6. AGE (In years lost birthday) <i>72</i> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS M.N.			
7a. BIRTHPLACE (State or foreign country) <i>Maine</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery Co.</i> Md					
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>SECTY.</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. MARITIME</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md.</i>			13b. COUNTY <i>mont.</i>		13c. CITY OR TOWN <i>SILVER SPRING</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>10121 Pierce Drive</i>		
14. FATHER'S NAME First Middle Last <i>EDWARD P. CONLEY</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>CATHERINE LOONEY</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16b. SOCIAL SECURITY NO <i>-</i>			17. INFORMANT <i>CATHERINE M. NEALE</i>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Breast c metastases</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6-8 mo</i>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>11</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>1947</i> to <i>22 March 1968</i> , that (I) (we) last saw the deceased alive on <i>22 March 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>William D. Aud</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>3/22/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>WILLIAM D AUD</i>						22e. ADDRESS <i>9006 Collesville RD.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <i>Mar. 26, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt Olivet Cem</i>			23d. LOCATION (City or Town) (County) (State) <i>Washington DC</i>			
24. FUNERAL DIRECTOR <i>H. Don. DeVol</i>						ADDRESS <i>2222 Wis. Ave</i>		25a. REC'D BY REGISTRAR DATE <i>MAR 27 1968</i>		25b. REGISTRAR'S SIGNATURE <i>James Judge</i>	



TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1003. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First Robert Middle G Last Cooke			2a. DATE KNOWN OF DEATH Month 3 Day 9 Year 1968			2b. HOJR M							
3 SEX male		4 RACE white		5 DATE OF BIRTH MAY 6, 1934		6 AGE (In years last birthday) 33 YRS		7c. DATE PRONOUNCED DEAD Month 3 Day 9 Year 1968		2d. HOUR M			
7a. BIRTHPLACE (State or foreign country) D. C.			7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md				
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) refrig. mechanic			12b. KIND OF BUSINESS OR INDUSTRY Refrigeration				
13a. USUAL RESIDENCE (Where deceased lived, if not in institution residence before admission) STATE Md.			13b. COUNTY Montgomery			13c. CITY OR TOWN Wheaton			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 2328 Glenmont Circle	
14. FATHER'S NAME First Warren Middle Spurgeon Last Cooke			15. MOTHER'S MAIDEN NAME First Nancy Middle Paul Last			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO 379-42-9037			17. INFORMANT Brother/James/4314 Judith St Rockville Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation due to DUE TO, OR AS A CONSEQUENCE OF Carbon Monoxide Intoxication Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year 3-9-68			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 18, item 18a) Deceased connected auto exhaust via hose thru window in car							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, etc.) Street			21f. LOCATION Street or R.F.D. No 2328 Glenmont Circle Wheaton Montgomery Md							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Belden R. Reap			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED MARCH 9, 1968				
EXAMINER'S NAME (Type) Belden R. Reap, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (City or Town, County, State) C. Glen Carter 8434 Georgia Ave. Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE March 12, 1968			23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Suitland, Maryland				
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.			25a. REC'D BY REGISTRAR MAR 13 1968			25b. REGISTRAR'S SIGNATURE Charles Judge							



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 - should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD 282
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04268

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
LINDA		B.	COX	MARCH 4 1968		330A M		
3 SEX	4 RACE		5. DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER - YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
FEMALE	CAUCASIAN		AUGUST 13, 1945		22 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
MARYLAND		USA				MONTGOMERY Md		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
BETHESDA		NAVAL HOSPITAL		SECRETARY		PRIVATE		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY U.S. 157		13e. STREET AND NUMBER
MARYLAND		ST. MARY'S		LEXINGTON PARK		NO		308 SWANEE PLACE
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
First Middle Last		First Middle Last						
G. W. BOURNE		MARIAN POWELL						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
NO				CHARLES D. COX 308 SWANEE PLACE MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE MITRAL VALVULITIS								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DISSEMINATED SYSTEMIC THROMBOSIS								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (A) (this hospital) attended the deceased from FEBRUARY 12 19 68, to MARCH 4, 19 68, that (X) (we) last saw the deceased alive on MARCH 4, 19 68, and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (do not) view the body after death.								
22b. SIGNATURE R. D. GASKINS								22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type) R. D. GASKINS								22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MARYLAND
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL		March 4, 1968		STANTON CEMETERY		STANTON, TENNESSEE		
24. FUNERAL DIRECTOR Joseph Gawler Sons Funeral Home				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
7557 Wisconsin Ave., N.W. Washington, D. C.				MAR 8 1968		Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

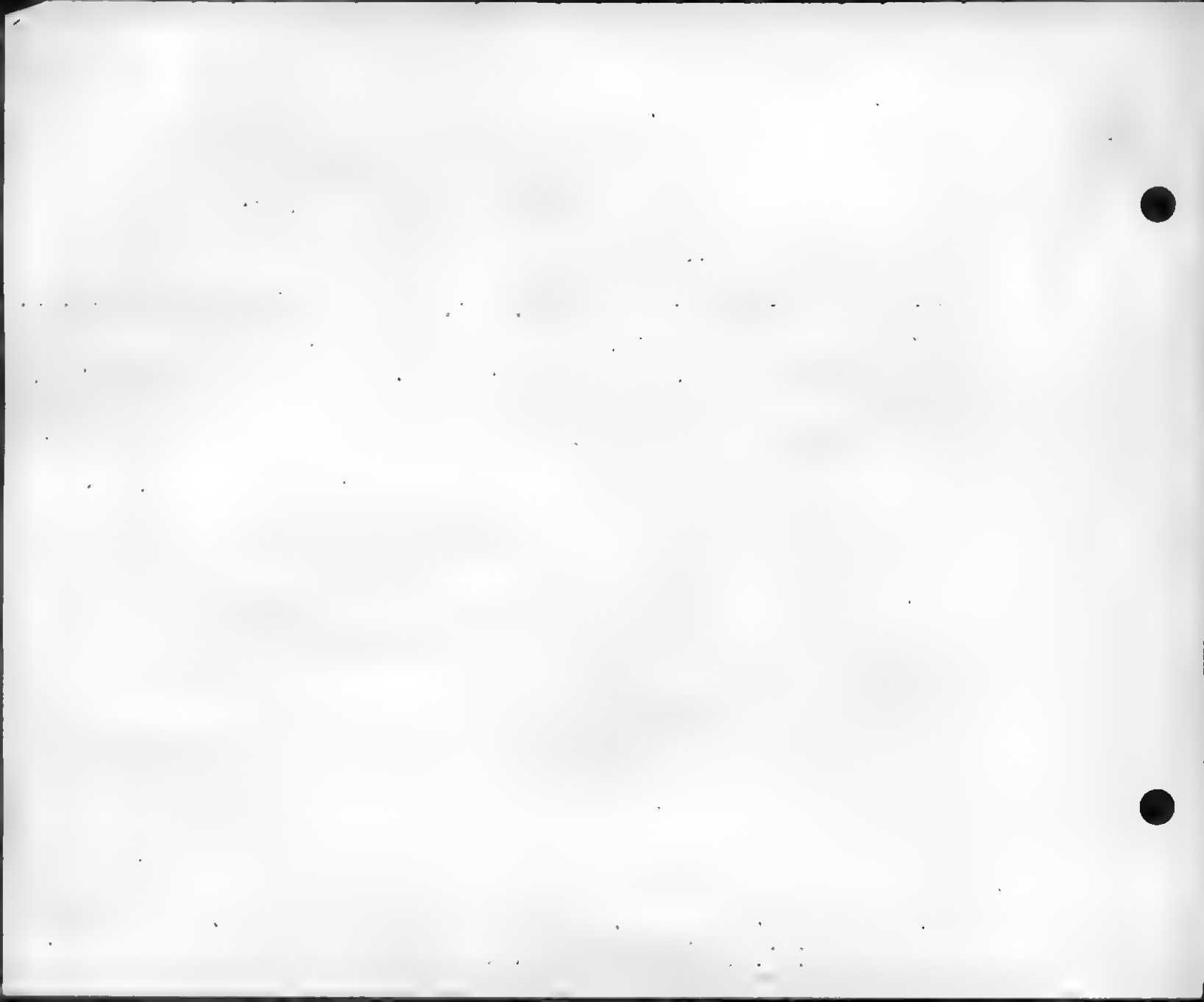
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30A REV. 1-7-60

34283 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Fannie Letitia Crittenden			2a. DATE OF DEATH 3 Month 19 Day 68 Year		2b. HOUR 6 30 P.M.
3. SEX F	4. RACE W	5. DATE OF BIRTH 2-6-70		6. AGE (In years last birthday) 98 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign) Calverton, Maryland	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Beltsville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Resnor		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Rtd	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Wash. D.C.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2730 Wisconsin Ave. N.W.	
14. FATHER'S NAME First Middle Last William Grey Street	15. MOTHER'S MAIDEN NAME First Middle Last Hannah Custer Davis				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO ---	17. INFORMANT John Crittenden 2730 Wisconsin Ave. NW Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Degeneration DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Diseases DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hr 5 yr + 10 yr +
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 1-13-68, 1968, to 3-19, 1968, that (I) (we) lost the deceased alive on 3-13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE Myrtle Post Baker M.D.			22c. DATE SIGNED 20069		
22d. PHYSICIAN'S NAME (Type) MYRTLE POST BAKER			22e. ADDRESS 1635 HARVARD ST		
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 3/22/68	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		23d. LOCATION (City or Town) (County) (State) Prince Georges County	
24. FUNERAL DIRECTOR The S.H. Hines Company 2901 14th St. N.W. Washington, D.C.			25a. REC'D BY REGISTRAR MAR 22 1968 DATE		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

IM

Items 5 & 6 File 6289-1/15/68
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) ANN E CROGHAN			2a. DATE OF DEATH Month MARCH Day 22 Year 1968			2b. HOUR 10:30 AM	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH 6/5/PM 1916		6. AGE (In years lost birthday) 51 YRS.	
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md	
10 CITY OR TOWN OF DEATH BETHESDA		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUBURBAN		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) IBM Supv.		12b. KIND OF BUSINESS OR INDUSTRY MERLATHOMAS Corp	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 4698 BATTERY LANE		14 FATHER'S NAME First Middle Last JAMES CROGHAN		15 MOTHER'S MAIDEN NAME First Middle Last MARY MOORE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO UNKNOWN		17 INFORMANT DONALD ABBOTT		Address KENSINGTON, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic adenocarcinoma to liver (Massive) 1522 DUE TO, OR AS A CONSEQUENCE OF (b) Primary adenocarcinoma of ileum DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 15							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1968 , to 1968 , that (I) (we) lost saw the deceased alive on 21 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE MARVIN HARRIS				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/22/68	
22d. PHYSICIAN'S NAME (Type) MARVIN HARRIS				22e. ADDRESS 8518 W. ...			
23a. BURIAL, CREMATION, REMOVAL (Specify) SHIP		23b. DATE 3-23-1968		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION (City or Town) (County) (State) Tuckerman New York	
24. FUNERAL DIRECTOR W.A. Chambers		ADDRESS 6 1400 Chapin St NW Wash D.C.		25a. REC'D BY REGISTRAR DATE MAR 27 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



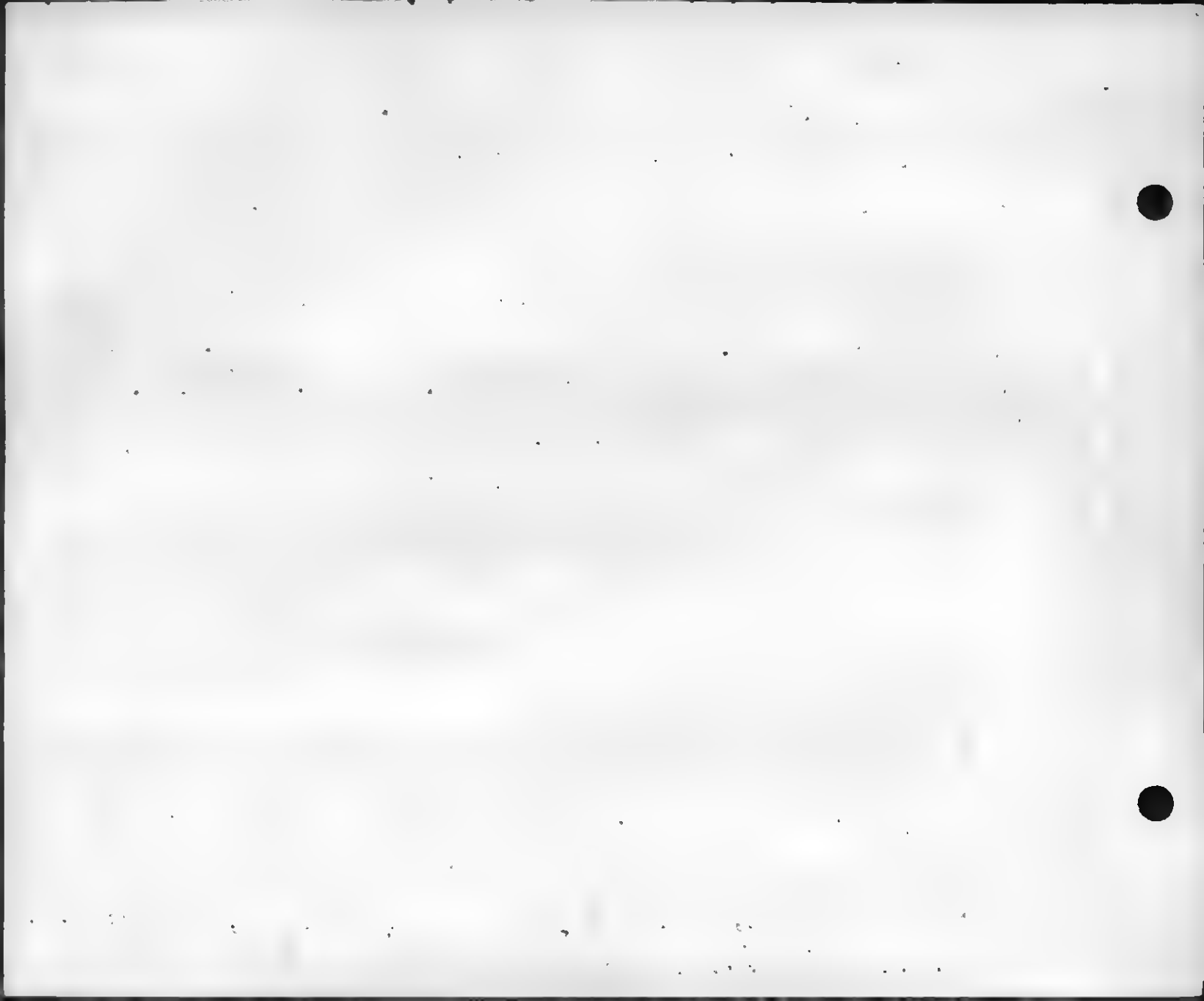
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VR A15 (4)
30M REV. 1/68

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Charles Herman Culler Sr.			2a. DATE OF DEATH Month 3 Day 1 Year 68			2b. HOUR 4:45 PM			
3. SEX male		4. RACE white		5. DATE OF BIRTH 3-4-1886			6. AGE (In years last birthday) 81 YRS.		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Wheaton			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Wheaton Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.			13b. COUNTY Washington			13c. CITY OR TOWN Washington		13d. INSIDE CITY, LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First William Middle L. Last Culler			15. MOTHER'S MAIDEN NAME First Jane Middle R. Last Wiles			16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes no, or unknown No (If yes give war or dates of service)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes no, or unknown No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 577 07 8047			17. INFORMANT Charles H. Culler, Jr. Bethesda, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 222X									
19a. DATE OF OPERATION 3-2-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 1-29 , 19 68 , to 3-1 , 19 68 , that (I) (we) last saw the deceased alive on 2-27 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Myron L. Lenkin					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/1/68		
22d. PHYSICIAN'S NAME (Type) Myron L. Lenkin					22e. ADDRESS 2309 Shorefield Rd Wheaton, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 5, 1968		23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		23d. LOCATION (City or Town) (County) (State) Middletown, Frederick, Md.			
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland					25a. REC'D BY REGISTRAR DATE MAR 7 1968		25b. REGISTRAR'S SIGNATURE Charles J. J...		



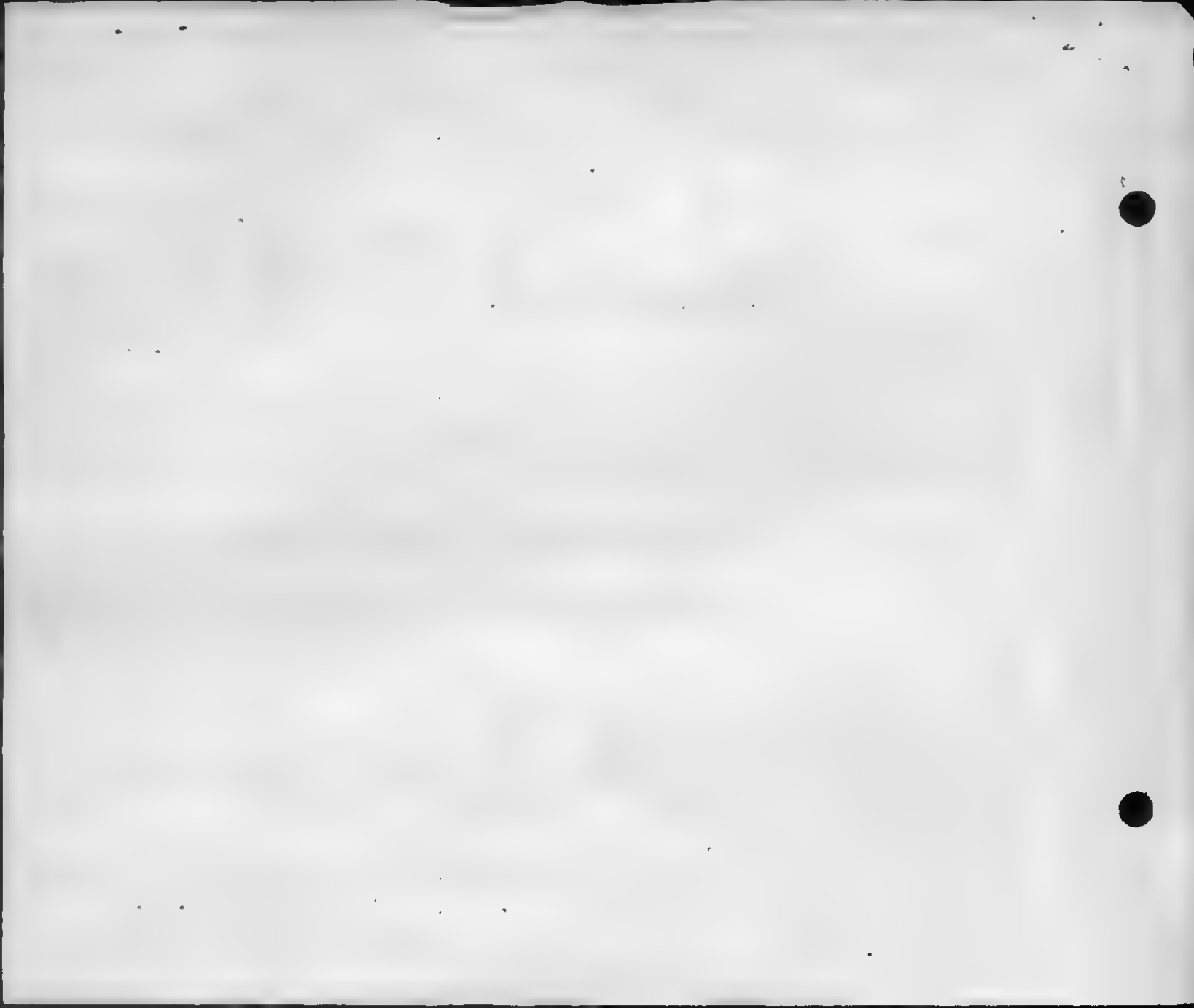
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>Yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5400 Pooks Hill Rd.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>5400 Pooks Hill Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FLORENCE</u> First Middle Last		4. DATE OF DEATH <u>DANIEL</u> Last <u>MARCH 18 1968</u> Month Day Year	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 20, 1879</u> 9. AGE (In years last birthday) <u>89</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>N. Carolina</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u> 14. MOTHER'S MAIDEN NAME <u>Cora Jackson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>Miss Etheleen Daniel</u> Address <u>Same as item #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>15 MIN</u> <u>10 YRS</u> <u>15 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JANUARY 1966</u> , to <u>MARCH 15, 1968</u> , that (I) (we) last saw the deceased alive on <u>MARCH 2, 1968</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Thomas F. O'Connor</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>THOMAS F. O'CONNOR M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>8218 WISCONSIN AVE, BETHESDA, MD</u> 22b. DATE SIGNED <u>3/18/68</u>	
23a. BURIAL, CREMATION, REMOVAL. (Specify) <u>Burial</u> 23b. DATE THEREOF <u>3/21/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u> 23d. LOCATION (City, town or county) (State) <u>Greenville, S. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAR 26 1968</u> 25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

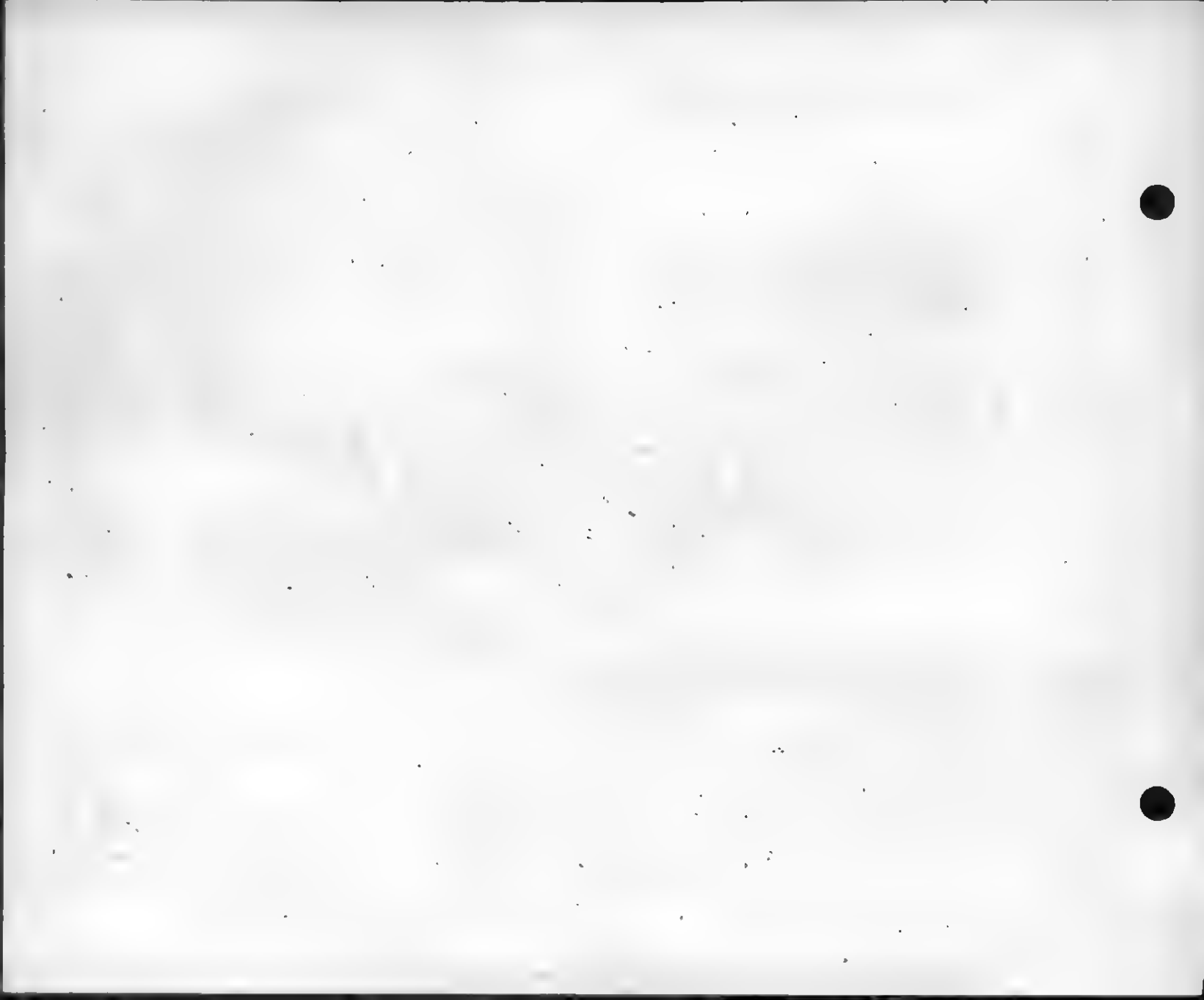
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VR A15 (4)
30M REV. 1/68

MD28.
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

MD27.1

1. DECEASED-NAME (Type or print) Ankie		First	Middle	Last	2a. DATE OF DEATH Month MARCH Day 15 Year 68		2b. HOUR 7:00 AM
3. SEX Female		4. RACE WHITE		5. DATE OF BIRTH 11/1/98		6. AGE (In years last birthday) 70 YRS	
7a. BIRTHPLACE (State or foreign country) md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery County Md	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospita. give street address) Holy Cross Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE WASHINGTON-D.C.		13b. COUNTY D.C.		13c. CITY OR TOWN D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 4910 KANSAS Ave. N.W.		14. FATHER'S NAME First William Middle A. Last Johnson		15. MOTHER'S MAIDEN NAME First Nellie Middle C. Last Bollman		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO. 579-16-8615		17. INFORMANT Leo P. Darr, Jr.		17. ADDRESS 1408 Legation Rd Chillum Md		18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 410.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Coronary Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Arterio-sclerosis PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Malignant Hypertension	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State		22a. I certify that (I) (the doctor) attended the deceased from 3/15/68 to 3/15/68 , that (I) (we) last saw the deceased alive on 3/15/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.		22b. SIGNATURE Francis X. Richardson	
22c. DATE SIGNED 3/15/68		22d. PHYSICIAN'S NAME (Type) Francis X. Richardson		22e. ADDRESS 11412 Viers Mill Rd., Wheaton, Md.		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 18, 1968		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or Town) (County) (State) Suitland Md.	
24. FUNERAL DIRECTOR F. J. ...		ADDRESS 304-14 ST N. WASH. D.C.		25a. REC'D BY REGISTRAR DATE MAR 19 1968		25b. REGISTRAR'S SIGNATURE Charles ...	



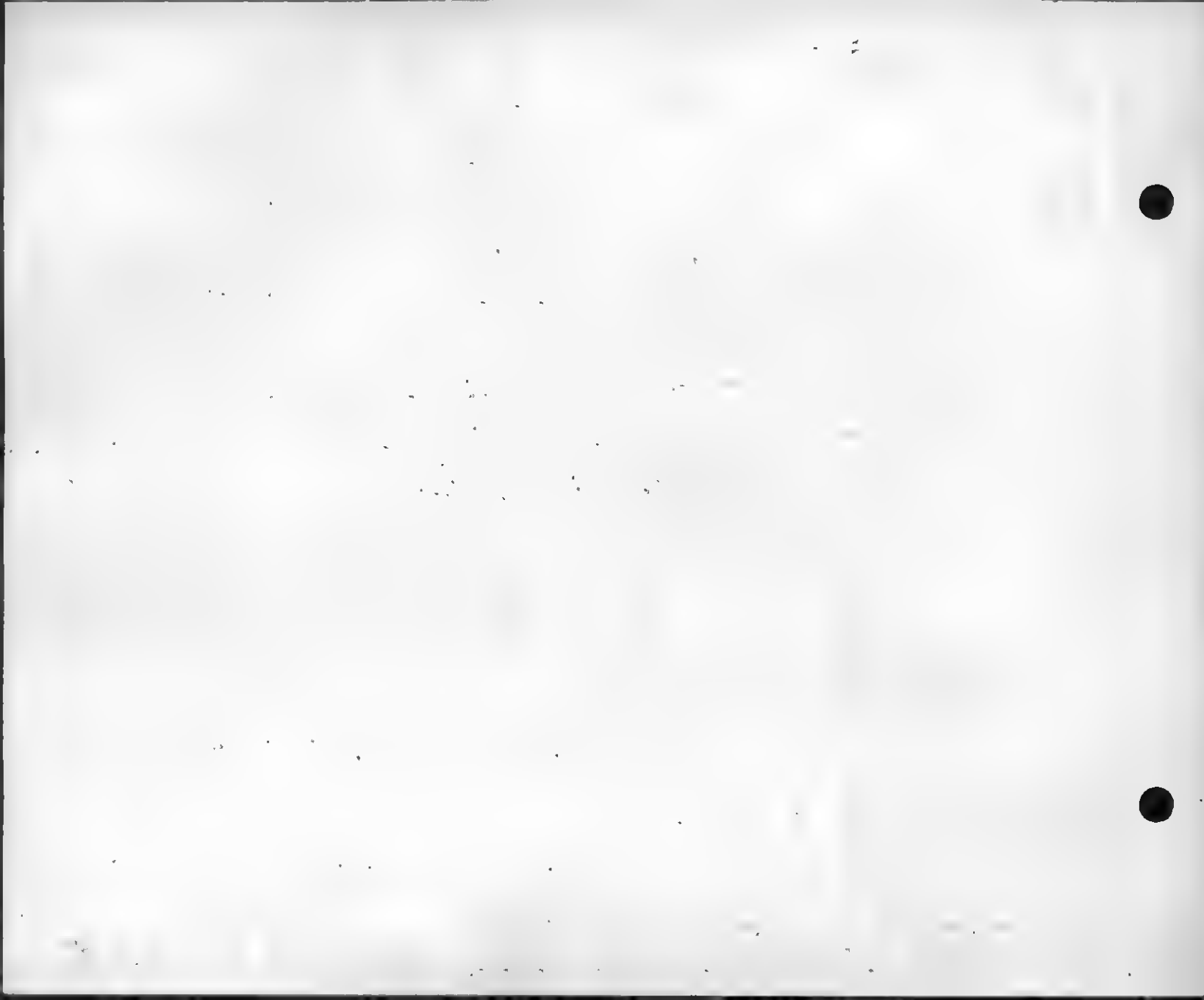
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VR A15 (4)
304 REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Barnie</i>		First <i>M</i> Middle <i>D</i> Last <i>Davies</i>		2a. DATE OF DEATH Month <i>March</i> Day <i>25</i> Year <i>1968</i>		2b. HOUR <i>4 M</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Oct. 11, 1888</i>		6. AGE (In years last birthday) <i>79</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>Indiana</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) <i>12,115 Willow Wood Drive</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Sil. Spr.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <i>Charles</i> Middle <i>H</i> Last <i>Davies</i>		15. MOTHER'S MAIDEN NAME First <i>Idah</i> Middle <i>Wolfe</i> Last <i></i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input type="checkbox"/> (or, unknown)		16b. SOCIAL SECURITY NO <i>306-57-1573</i>		17. INFORMANT Address <i>Charles H. Davies 12,115 Willow Wood Drive</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure</i>							<i>2 weeks</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>402 X</i>							
(b) <i>History of hypertension</i>							<i>2 years</i>
(c) <i></i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>443 X</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec 18, 1967</i> , to <i>Mar 26, 1968</i> , that (I) (we) last saw the deceased alive on <i>3-24-</i> <i>1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>John H. Andrews M.D.</i> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						22c. DATE SIGNED <i>3-26-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>John H. Andrews</i>						22e. ADDRESS <i>9601 Colesville Rd Silver Spring Md</i>	
23a. B. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>3/30/1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cath. Hill Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Loanville Indiana</i>	
23e. FUNERAL DIRECTOR <i>James E. Pumphrey Inc. 8434 Ta. Ave. S.E., Md</i>				25a. REC'D BY REGISTRAR <i>AF 29 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



Cleared with Dr. Reap. bb

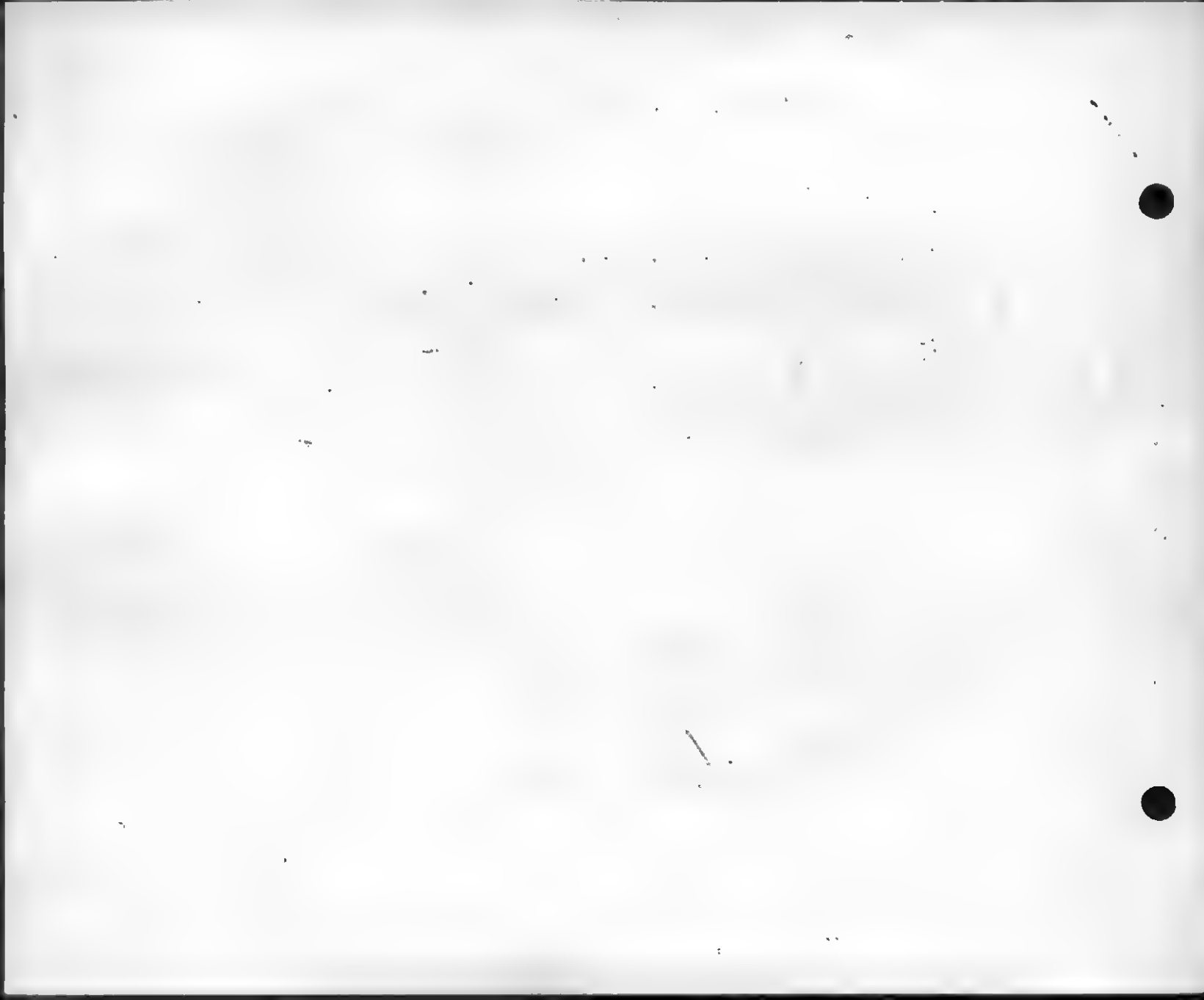
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 540
30M REV. 7/58

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last SRUHEE (NONE) DAVITIAN			2a. DATE OF DEATH Month Day Year 3-5-68			2b. HOUR 5:53	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 4-5-05		6. AGE (In years last birthday) YRS. 62	
7a. BIRTHPLACE (State or foreign country) Armenia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Wash. San. & Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY At Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Mont.		13c. CITY OR TOWN S. S. XXXXXXXXXX		13d. INS DE CITY LIMITS? NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last John Ayanian		15. MOTHER'S MAIDEN NAME First Middle Last Rupega		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No			
16b. SOCIAL SECURITY NO NONE		17. INFORMANT Address 8900 WALDEN RD Mr. Karnig Davitian - Husband SLAVEN JUDILL					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION 4		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21c. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1955 , 19____, to 3-5 , 19 68 , that (I) (we) last saw the deceased alive on 3-3-68 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE M. Snow, M.D. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c. DATE SIGNED 3-6-68			
22d. PHYSICIAN'S NAME (Type) M. SNOW M.D.				22e. ADDRESS 9012 Fitch Ave - Cinc			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE MARCH 9, 1968		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION (City or Town) (County) (State) BLADENSBURG MD	
24. FUNERAL DIRECTOR W. W. Chambers ADDRESS 1400 Chapin ST N.W.				25a. REC'D BY REGISTRAR MAR 8 1968		25b. REGISTRAR'S SIGNATURE Johnas Judge	

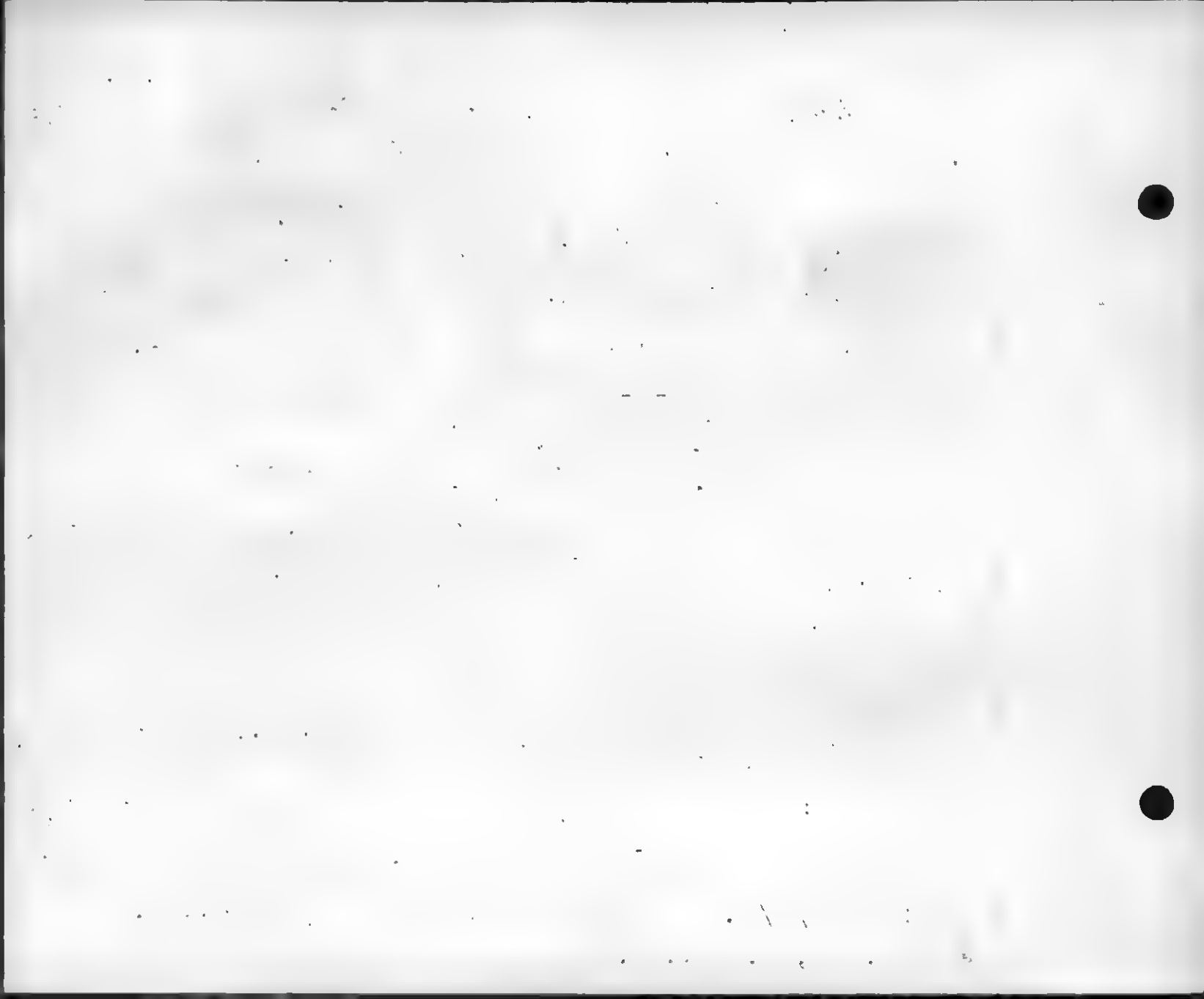


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) HARRY S. Deckard			2a. DATE OF DEATH March 14 Day 1968 Year		2b. HOUR 1:15 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH 9/11/82		6. AGE (In years lost birthday) 85 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Pa.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Stewart	12b. KIND OF BUSINESS OR INDUSTRY B&O RR		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INS-DE CITY Y.M. 15? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 100 E Wayne Ave	
14. FATHER'S NAME First James Middle Deckard Last Deckard		15. MOTHER'S MAIDEN NAME First Ella Middle Seebold Last Seebold			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 705-09-9562		17. INFORMANT Address Mrs Barbara T Deckard Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary arrest 410.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 420.1 (b) Myocardial infarction & arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Renalized arteriosclerosis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH mins Days years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) CVA-stroke, peripher, chron bronchitis & emphysema.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED <input type="checkbox"/> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from March 3, 1968 , to March 14, 1968 , that (I) (we) lost saw the deceased alive on March 14, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Harold W. Draper M.D. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c. DATE SIGNED March 14, 1968	
22d. PHYSICIAN'S NAME (Type) HAROLD W. DRAPER M.D.		22e. ADDRESS 9801 GEORGIA AVE, Silver Spring			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/18/68.		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	
23d. LOCATION (City or Town) Baltimore, Md.		23e. (County) Baltimore		23f. (State)	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS		25a. REC'D BY REGISTRAR MAR 18 1968	
				25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, ~~burial~~ ^{burial} ~~pages 1 and 2~~ ^{pages 1 and 2} should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Item 6 Film G399 3/27/68 kk											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) First Middle Last <i>Andrew Paul Dedick</i>						2a. DATE OF DEATH Month Day Year <i>March 17, 1968</i>			2b. HOUR <i>11:25 AM</i>		
3. SEX <i>Male</i>		4. RACE <i>Cauc.</i>		5. DATE OF BIRTH <i>July 4, 1891</i>			6. AGE (In years last birthday) <i>76</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>Penn.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>			Md		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Bethesda-Silver Spring Nursing</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Priest</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Clergy</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <i>STAYE Penn.</i>			13b. COUNTY <i>✓ Mt. Carmel</i>		13c. CITY OR TOWN <i>✓ Mt. Carmel</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>131 N. Willow St.</i>		
14. FATHER'S NAME First Middle Last <i>Paul Dedick</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Pearl (unknown)</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>unknown</i>			16b. SOCIAL SECURITY NO <i>185-30-6702</i>		17. INFORMANT <i>Higgins Funeral Home 45 Market Street, Mt. Carmel, Pennsylvania</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>434.9</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral embolism - old and recent</i> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>6 days</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING NO <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <i>January 17, 1968</i> to date <i>March 16</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>March 16</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>John G. Ball M.D.</i>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>3/17/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>John G. Ball</i>						22e. ADDRESS <i>7936 Old Georgetown Rd., Bethesda, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>March 19, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Michael's Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Mt. Carmel, Pennsylvania</i>				
24. FUNERAL DIRECTOR (Name) <i>Clark E. Minor</i>						ADDRESS <i>11401 E. Pumphrey, Inc. Silver Spring, Md.</i>		25a. RECD BY REGISTRAR DATE <i>MAR 21 1968</i>		25b. REGISTRAR'S SIGNATURE <i>James J. Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 1-14
304 REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) MARION		First	Middle	Lost	2a. DATE OF DEATH Month MARCH Day 26 Year 68			2b. HOUR 1:35 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 4/8/21		6. AGE (In years lost birthday) 46 YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) PENNA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY		Md.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUBURBAN		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6709 BUTTERMERE LANE	
14. FATHER'S NAME First FAY Middle X Last FIELD		15. MOTHER'S MAIDEN NAME First HELEN Middle ENGLISH Last		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT CAROLYN ROBINSON - SISTER - WASHINGTON, PA.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of Rectum with Pelvic Metastasis DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 1/2 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 154x									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR AM Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from Jan. 15, 1963 , to March 26, 1968 , that (I) (we) last saw the deceased alive on March 26, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Stanley M. Bialek						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 26 March 1968	
22d. PHYSICIAN'S NAME (Type) STANLEY M. BIALEK		22e. ADDRESS 8218 Wisconsin Ave. - Beth. Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-29-68		23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Maryland			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland				25a. RECORD REGISTRAR APR 1 - 1968		25b. REGISTRAR'S SIGNATURE [Signature]			



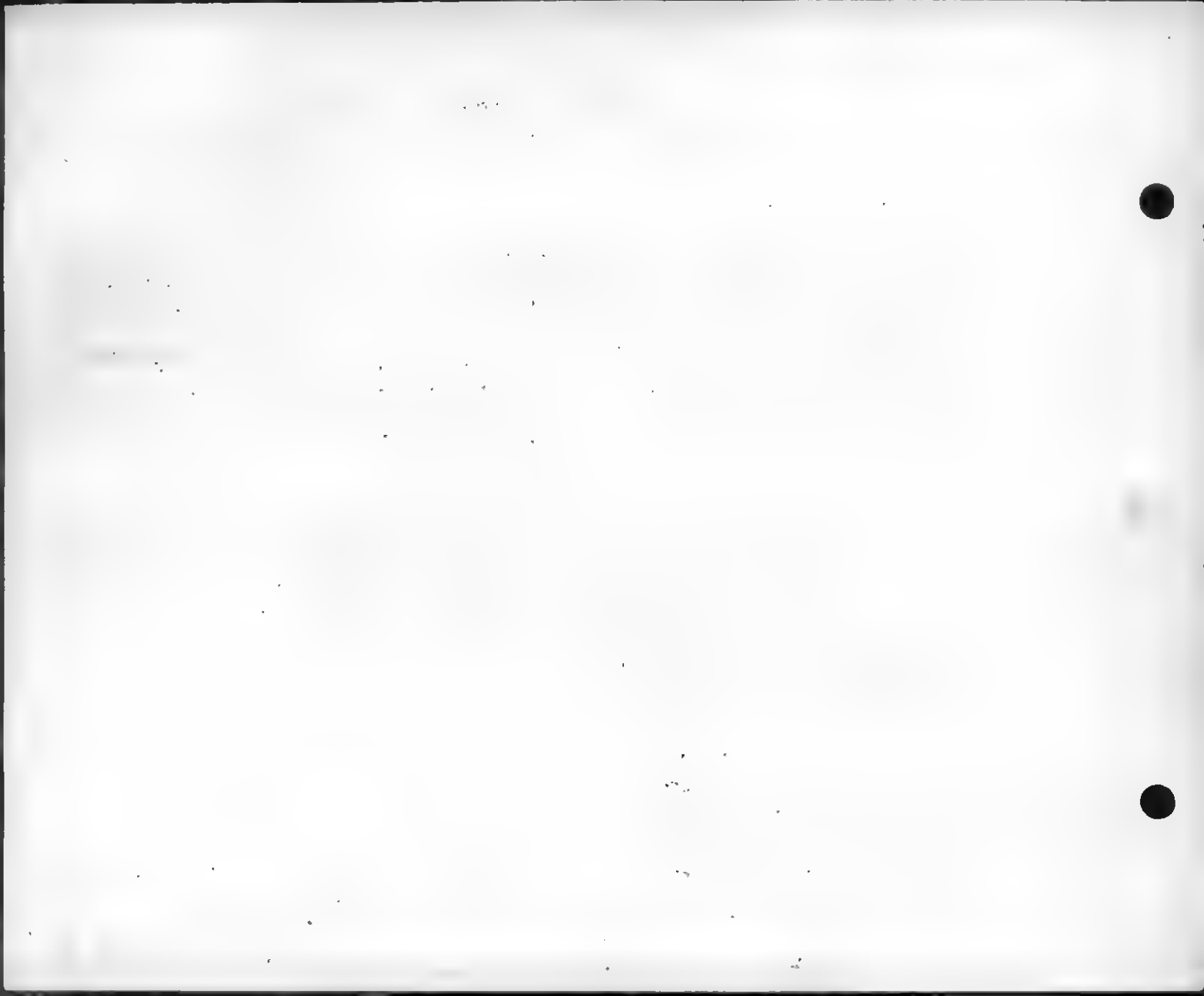
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Christine Marie DESPRES			2a. DATE OF DEATH Month March Day 21 Year 1968			2b. HOUR 1134 M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH March 20, 1968		6. AGE (In years lost birthday) YRS. MONTHS DAYS 1 3 4	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) N/A		12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. USUAL RESIDENCE (Where deceased lived, if institut on admission) STATE Virginia		13b. COUNTY Arlington		13c. CITY OR TOWN Arlington		13e. STREET AND NUMBER Dr. Apt. 10 704 South Arlington Mill	
14. FATHER'S NAME First Middle Last Raymond J. Despres			15. MOTHER'S MAIDEN NAME First Middle Last Nancy Fryman				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT Dr. Apt. 10, Arlington Va. CPL Raymond J. DESPRES, 704 S. Arlington Mill			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Immature Newborn</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>7</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21c. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>March 20</u> , 19 <u>68</u> , to <u>March 21</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>March 21</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Gene P. Swartz</u>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 22 March 1968	
22d. PHYSICIAN'S NAME (Type) Gene P. Swartz, M.D.				22e. ADDRESS Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3-25-68		23c. NAME OF CEMETERY OR CREMATORY MT. HOPE		23d. LOCATION (City or Town) (County) (State) SAN DIEGO Calif	
24. FUNERAL DIRECTOR Murphy Funeral Home				25a. REC'D BY REGISTRAR DATE APR 3, 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form "M-3" Page 5 may be retained for your files.

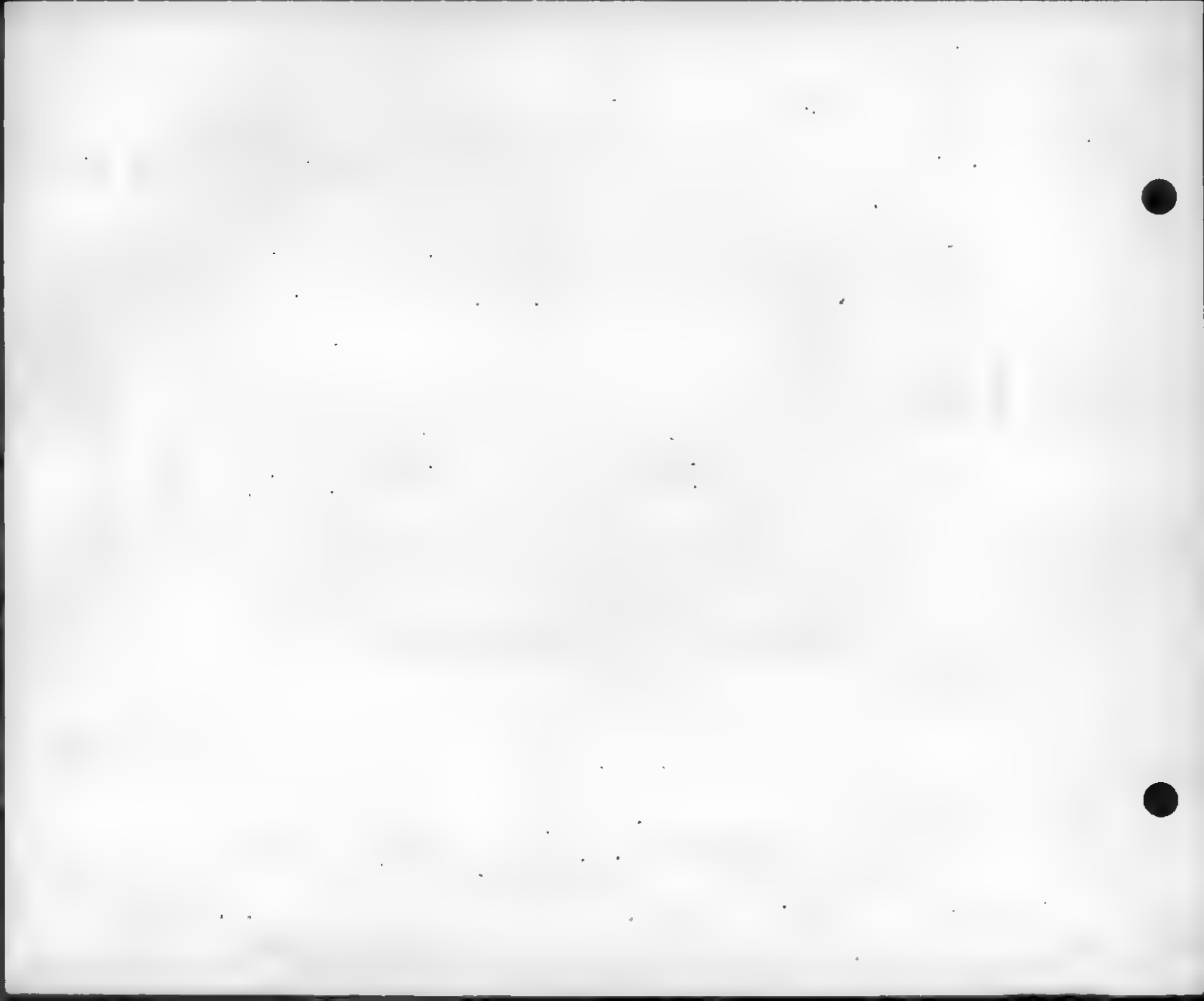
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1 SME (S)
10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 DECEASED NAME (Type or Print)		First MARIA		Middle ELOISE		Last DI CAMILLO		2a DATE KNOWN OF DEATH		ESTIMATED Month 3 Day 3 Year 1968		2b HOUR 10:50 AM			
3 SEX Female		4 RACE White		5 DATE OF BIRTH 5/5/05		6 AGE (in years last birthday) 62 YRS		7 IF UNDER 1 YEAR MONTHS _____ DAYS _____		8 IF UNDER 24 HRS HOURS _____ MIN. _____		2c DATE PRONOUNCED DEAD Month March Day 3 Year 1968			
7a BIRTHPLACE (State or foreign country) Italy		7b CITIZEN OF WHAT COUNTRY? Italy		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery						2d HOUR 10:50 AM			
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b KIND OF BUSINESS OR INDUSTRY -									
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Sil. Spr.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1501 Dilston Rd.							
14. FATHER'S NAME First Carmine Middle Orlando Last Giovina		15 MOTHER'S MAIDEN NAME First Evangelista Middle Lucia Last Hudgins													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. No		17. INFORMANT Daughter,		ADDRESS Lucia Hudgins 7007 Hillmeade Rd. Bowie, Md.									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Insufficiency 4124 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) +															
19a. DATE OF OPERATION 3/6/68				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Heart Disease				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____											
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion															
ACTUAL SIGNATURE Belden R. Read EXAMINER'S NAME (Type) BELDEN R. READ M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, City or Town, or County) 1501 Dilston Rd. Silver Spring, Md.				22b DATE SIGNED MARCH 3, 1968							
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 3/6/68		23c NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery				23d LOCATION (City or Town) (County) (State) Wash., D.C.							
24. FUNERAL DIRECTOR Valley's Funeral Home Inc.				ADDRESS 1111 1st. Rainier, Maryland				25a REC'D BY REG. STRAR DATE MAR 7 1968				25b REG. STRAR'S SIGNATURE Charles J. [Signature]			



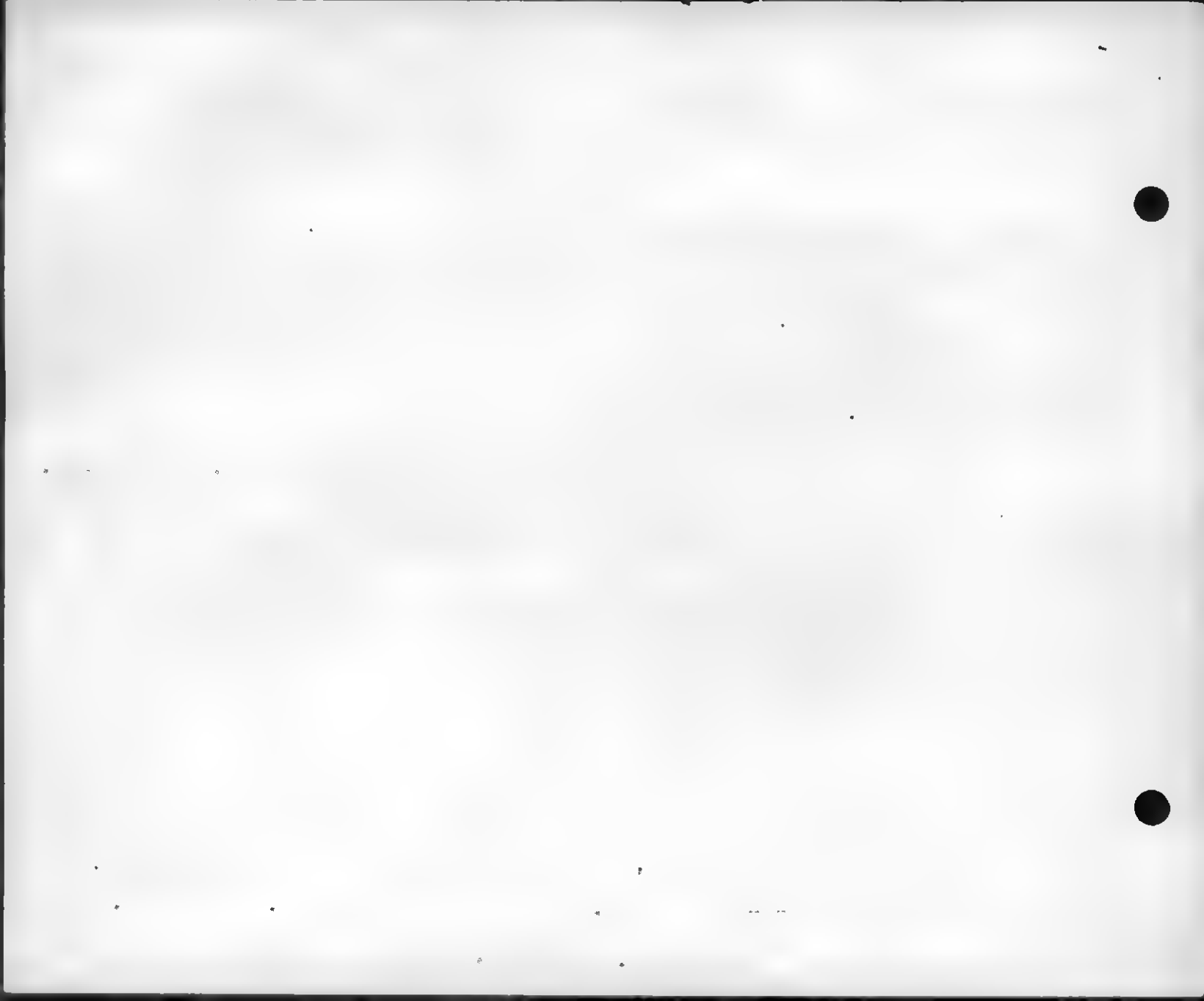
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Heaton</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>Montgomery</u>	
c. LENGTH OF STAY IN 1b <u>5 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home</u>		d. STREET ADDRESS <u>2407 15th St., NW</u>	
3 NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>M.</u> Last <u>Dombrow</u>		4 DATE OF DEATH Month <u>3</u> Day <u>4</u> Year <u>1968</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>Cauc.</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4/26/1896</u>
9 AGE (In years lost birthday) <u>71</u> yrs.		10 IF UNDER 1 YEAR Months <u>3</u> Days <u>4</u> Hours <u>19</u> Min. <u>68</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Government worker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) <u>Louiston, Maine</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John P. Mac Donald</u>		14. MOTHER'S MAIDEN NAME <u>Anna Green</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>068-01-2846</u>	
17 INFORMANT <u>Joseph Silberstein, Nephew</u>		Address <u>5006 Alta Vista Rd. Bethesda, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u> <u>1957</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Extensive poorly differentiated Ca. neck</u> DUE TO (c) <u>1 yr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 yr.</u>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>29 JAN, 1968</u> to <u>4 MAR, 1968</u> that (I) (we) last saw the deceased alive on <u>4 MAR 1968</u> and that death occurred at <u>1:05 PM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Pyron Lenkin, M.D.</u>		22b. DATE SIGNED <u>3/4/68</u>	
22c. PHYSICIAN'S NAME (Type) <u>Pyron Lenkin, M.D.</u>		22d. ADDRESS <u>2309 Shorefield Rd., Heaton, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or town) (County) (State)
<u>Cremation</u>	<u>3-4-68</u>	<u>Ft. Lincoln Crematory</u>	<u>Mt. Rainer Pr. Geo Md</u>
24 FUNERAL DIRECTOR <u>Robert A Pumphrey</u>		25a. REC'D BY REGISTRAR <u>4557 Wisconsin Ave. Bethesda, Md</u>	
25b. REGISTRAR'S SIGNATURE <u>phoenix pages</u>		DATE <u>MAR 8 1968</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD 29
M
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last SYLVIA G. LONOVAN			2a. DATE OF DEATH Month Day Year March 15 1968			2b. HOUR 7 A M	
3. SEX Female		4. RACE white		5. DATE OF BIRTH Nov-18 1886		6. AGE (In years last birthday) YRS. MONTHS DAYS 81	
7a. BIRTHPLACE (State or foreign country) Penna		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Colonial Villa		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY at Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE md		13b. COUNTY Pr. Geo		13c. CITY OR TOWN Takoma Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER Sycamore Avenue		14. FATHER'S NAME First Middle Last John Greene		15. MOTHER'S MAIDEN NAME First Middle Last Ada F. Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO 486x		17. INFORMANT James W. Palmer		Address 2311 Apache St. Adelphi	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 486x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 493x carcinoma ca of the breast							
19a. DATE OF OPERATION Feb 1967		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca breast		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 2/12 , 1968, to 3/15 , 1968, that (I) (we) lost saw the deceased alive on 3/12 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R.H. Sandstrom MD				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/15/68	
22d. PHYSICIAN'S NAME (Type) R.H. Sandstrom MD				22e. ADDRESS 7701 Carroll Ave Takoma Park, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE March 19 1968		23c. NAME OF CEMETERY OR CREMATORY Mount Comfort		23d. LOCATION (City or Town) (County) (State) Alexandria Va.	
24. FUNERAL DIRECTOR Arthur Waller				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	
ADDRESS 254 Carroll Ave Washington, D.C. 20002				DATE MAR 19 1968			



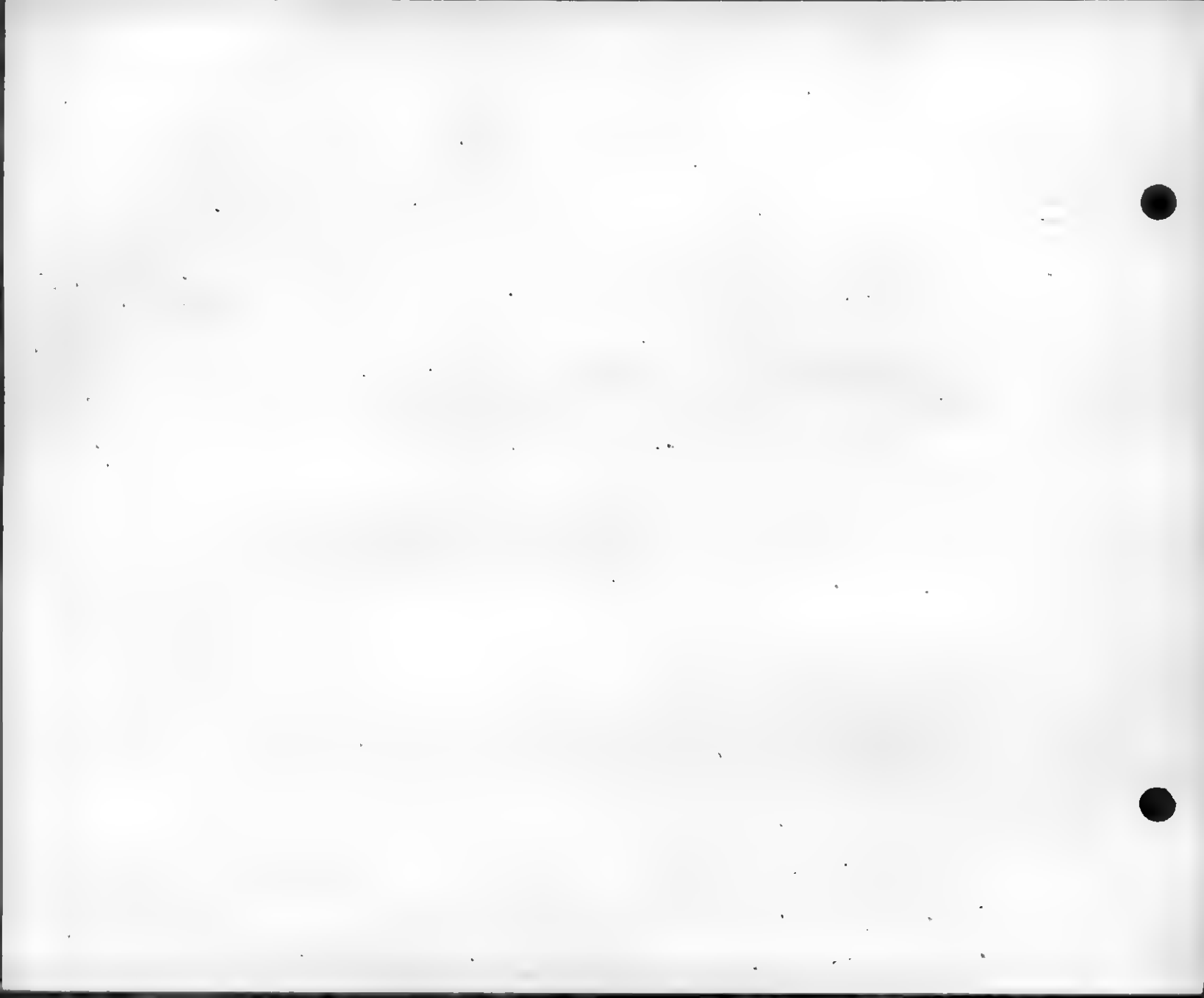
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 115 (10)
304 REV 1-68

<div style="text-align: center;"> <p>34297</p> <p>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</p> <p>CERTIFICATE OF DEATH</p> <p style="text-align: right;">4283</p> </div>																	
1. DECEASED NAME (Type or print)			First GEORGE			Middle B			Last DORSEY			2a. DATE OF DEATH 3 Month 24 Day 68 Year			2b. HOUR 5:20am		
3 SEX Male			4. RACE Negro			5. DATE OF BIRTH 8/7/87			6. AGE (In years lost birthday) 80 YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md								
10. CITY OR TOWN OF DEATH Olney			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Handyman			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Echison			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER Box 247 Rt. #2 Gaithersburg, Maryland					
14. FATHER'S NAME First Nelson			Middle Dorsey			Last Dorsey			15. MOTHER'S MAIDEN NAME First Roseanna			Middle Warren			Last Warren		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT Medical Records Montgomery General Hospital			Address Olney, Md. 20832								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Transmitted with carcinoma of bladder -</i> <i>188X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>1870</i> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Leukemia and Anemia</i>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town			County			State		
22a. I certify that (I) (this hospital) attended the deceased from <i>2/14</i> , 19 <i>67</i> , to <i>2/24</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>2/23</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>John D. Maylath, MD</i>			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED								
22d. PHYSICIAN'S NAME (Type) John D. Maylath, MD			22e. ADDRESS 50 W. Edmonston Drive Rockville, Maryland 20851														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 3-28-68			23c. NAME OF CEMETERY OR CREMATORY Brooke Grove			23d. LOCATION (City or Town) Laytonsville Montg. Md.			(County)			(State)		
24. FUNERAL DIRECTOR <i>R. L. Snawder, Rockville, Md.</i>			ADDRESS			25a. REC'D BY REGISTRAR DATE <i>MAR 29 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>								

MEDICAL CERTIFICATION



CERTIFICATE OF DEATH

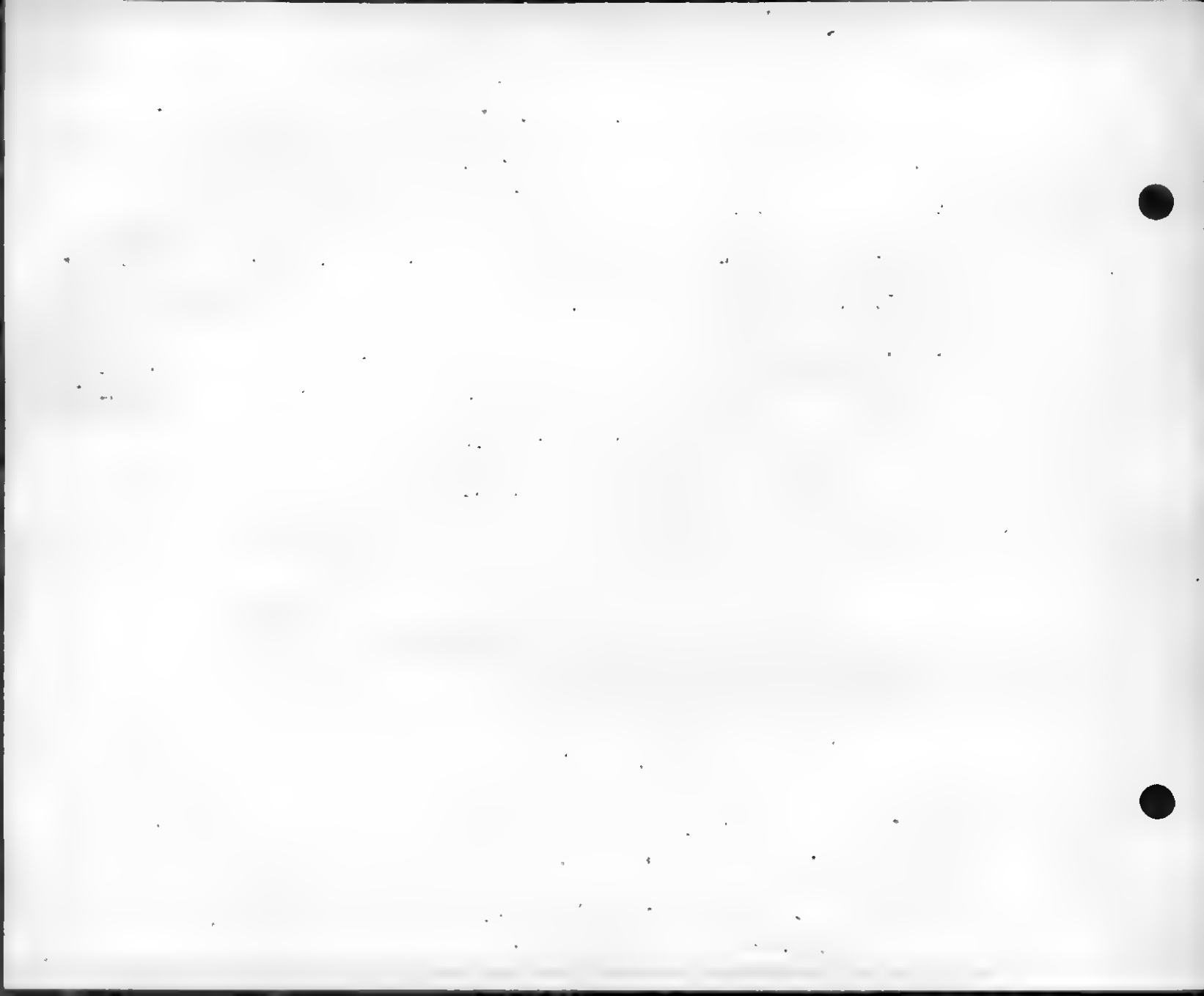
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34

1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR				
Stephen P. DORSEY						March 10 68			1235 ^{AM}				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
Male		Caucasian		Sept. 13, 1913			54						
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md	
Nebraska			U.S.						Montgomery				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
Bethesda			Naval Hospital			Foreign Service			Consulate				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER	
D. C.						Washington			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			2823 Q Street,	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last										
Guy P. Dorsey			Julia Geisthardt										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO (If yes give war or dates of service)			17. INFORMANT Address			D. C.				
No			Unknown			Carolyn C. Dorsey, 2823 Q St. N.W. Washington							
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized carcinomatosis													
1890 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
(b) Adenocarcinoma left kidney													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town			County State	
22a. I certify that (I) (this hospital) attended the deceased from December 10, 1967, to March 10, 1968, that (I) (we) last saw the deceased alive on March 10, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and I alone) view the body after death.													
22b. SIGNATURE Lawrence A. Jones, M. D.								DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 11 March 1968			
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Cremation			3/11/68			Cedar Hill Crematory			Suitland, Md.				
24. FUNERAL DIRECTOR ADDRESS Jos. Gawler's Sons Funeral Home 5130 Wisconsin Ave., N.W. Washington, D. C.								25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE MAR 14 1968			

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.



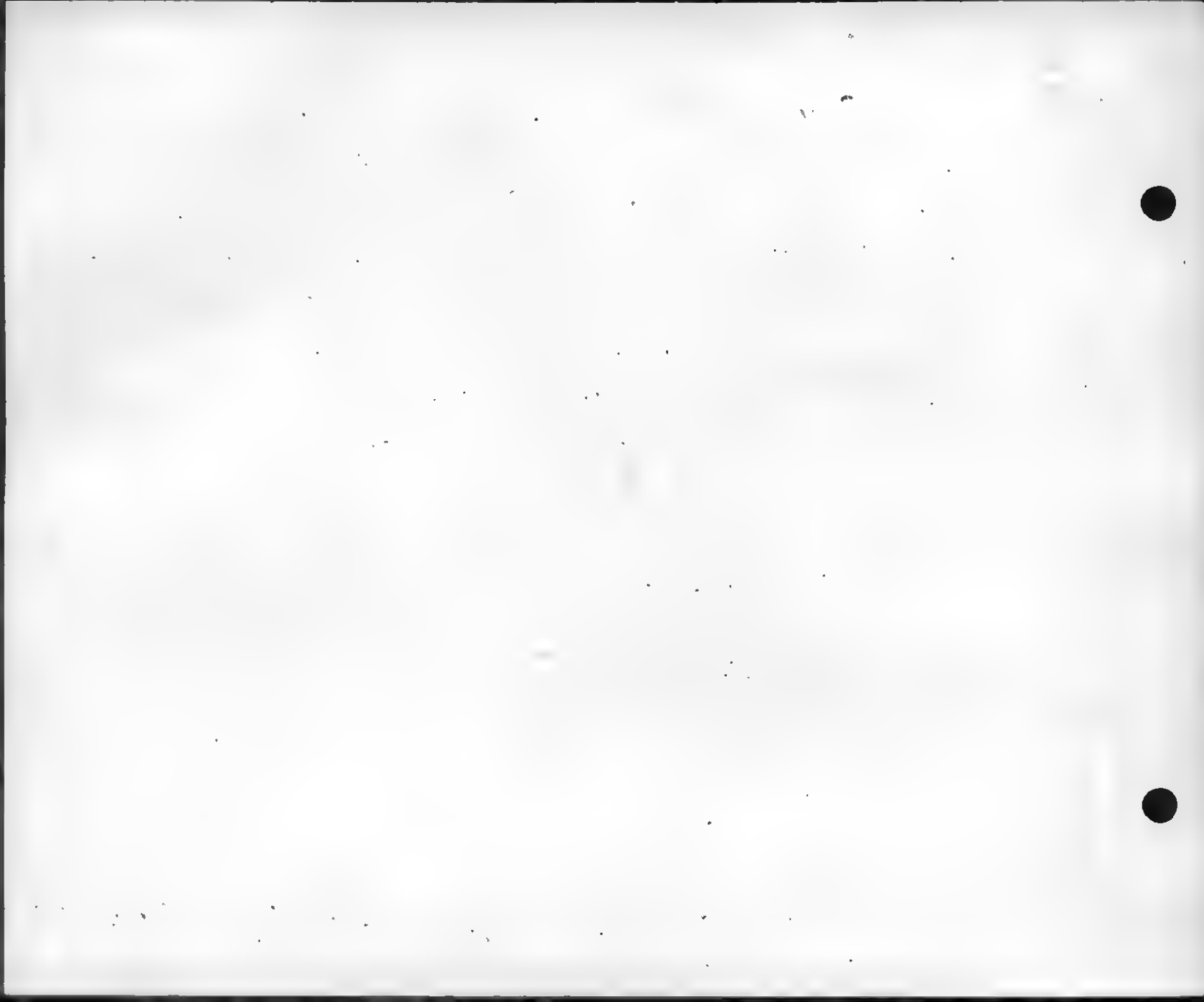
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD295
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04285

1. DECEASED-NAME (Type or print) First Middle Last <i>Paul Sidney Douglas</i>			2a. DATE OF DEATH Month Day Year <i>March 23 1968</i>			2b. HOUR <i>3:42 P</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>2-25-07</i>		6. AGE (In years lost birthday) <i>61 YRS.</i>	
7a. BIRTHPLACE (State or foreign country) <i>West. Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md	
10. CITY OR TOWN OF DEATH <i>Takoma Park, Md.</i>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Wash. San & Hosp.</i>		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) <i>Magn. Periodical Dept.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>R & H Pub.</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Takoma Park</i>		13c. CITY OR TOWN <i>Takoma Park</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>704 Chaney Drive</i>		13f. APARTMENT, BUILDING, OR BOX NO. <i>Ass'n.</i>		13g. STREET AND NUMBER <i>704 Chaney Drive</i>		13h. APARTMENT, BUILDING, OR BOX NO. <i>Ass'n.</i>	
14. FATHER'S NAME First Middle Last <i>Troy Douglas</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Ella Elvis</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. <i>214-36-1685</i>		17. INFORMANT <i>Med. Records</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Retroposterior Sarcoma</i> <i>1.5000</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Bone Marrow depression</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 1966</i> to <i>March 23, 1968</i> , that (I) (we) last saw the deceased alive on <i>March 23</i> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) did not view the body after death.							
22b. SIGNATURE <i>R. H. Sandstrom MD</i>		DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>March 23, 1968</i>	
22d. PHYSICIAN'S NAME (Type) <i>R. H. Sandstrom MD</i>		22e. ADDRESS <i>7701 Carroll Ave. Takoma Park, Md</i>					
23a. BURIAL, CREMATION, or other disposition <i>Burial</i>		23b. DATE <i>MAR 26, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>F. LINCOLN CEMETERY</i>		23d. LOCATION (City or Town) County (State) <i>Bethesda D. C. Geo 6 Md.</i>	
24. FUNERAL DIRECTOR <i>Takoma Funeral Home</i>		24a. ADDRESS <i>254 Carroll St. N.E.</i>		25a. REC'D BY REG. STRAR <i>DATE MAR 26 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF OF ESTI- OATH MATED			Month Day Year	2b HOUR
Christopher F. DOWNER						3 17 1968			10 ⁰⁵ AM	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD			2d HOUR	
Male	Cauc	Sept. 28, 1949	18 YRS			Month Day Year			10 ⁰⁷ AM	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Georgia		USA				Montgomery			MD	
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			2e USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY	
Bethesda			Naval Hospital			U. S. Army				
13a U.S.A. RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY		13c CITY OR TOWN	13d INS DE CITY, WTS?		13e STREET AND NUMBER		
Virginia					Alexandria	YES <input type="checkbox"/> NO <input type="checkbox"/>		307 Summers Drive		
14 FATHER'S NAME			15 MOTHER'S MARDEN NAME							
First Middle Last			First Middle Last							
William F. Downer			Hattie Kay Whipple							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT			ADDRESS		
Yes 5-24-68			228070728		Alexandria			Virginia		
						Mr. William F. Downer, 307 Summers Drive				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Meningitis due to Pseudomonas Specie -</u>									<u>48 days</u>	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Status Post Laminectomy</u>									<u>70 days</u>	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Trauma</u>									<u>98 days</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION									20. AUTOPSY?	
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			4:29 PM Dec. 10 1967		Struck by Fork Lift					
21d INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.D. No.		City or Town		County State		
		Camp		2nd Log Command		OKINAWA				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b DATE SIGNED				
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER			March 18, 1968				
John G. Ball, M. D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial			3/20/68		Arlington National Cemetery		Arlington, Virginia			
24 FUNERAL DIRECTOR Falls Church Funeral Home					25 REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
1102 West Broad St., Falls Church, Va.					MAR 21 1968		Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) <i>William G. Dunkley</i>			2a. DATE OF DEATH Month <i>March</i> Day <i>9</i> Year <i>1968</i>			2b. HOUR <i>9:30</i> P.M.	
3. SEX <i>Male</i>		4. RACE <i>Cauc.</i>		5. DATE OF BIRTH <i>Oct. 12, 1886</i>		6. AGE (in years last birthday) <i>81</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>England</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md	
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>8612 Garland Avenue</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Mechanical Engineer</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Takoma Park</i>		13d. INSIDE CITY LIM TSP <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
13e. STREET AND NUMBER <i>8612 Garland Avenue</i>		14. FATHER'S NAME First <i>William</i> Middle <i>Dunkley</i> Last <i>Dunkley</i>		15. MOTHER'S MAIDEN NAME First <i>Edith</i> Middle <i>Mur</i> Last <i>Mur</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>168-07-8565</i>		17. INFORMANT <i>Mrs. Clara Dunkley</i>		17. ADDRESS <i>8612 Garland Avenue, Takoma Park, Maryland</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Colon</i> <i>1538</i> DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12-15 mo</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>1949</i> to <i>1968</i> , that (I) (we) last saw the deceased alive on <i>5 March 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>William D. And</i> M.D. DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>March 11, 1968</i>	
22d. PHYSICIAN'S NAME (Type) <i>William D. And</i>				22e. ADDRESS <i>9006 Colesville Road, Silver Spring, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>March 12, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Prince Georges County, Md.</i>	
23e. ADDRESS <i>Warner E. Pumphrey, Inc. Silver Spring, Md.</i>				25a. REC'D BY REGISTRAR <i>MAR 13 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>	



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MD302
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) JOHN		First TEESDALE		Middle DUVALL		Last DUVALL		2a. DATE OF DEATH Month MARCH Day 15 Year 1968		2b. HOUR 11:50 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH FEB. 28, 1883		6. AGE (In years last birthday) 85 YRS		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN 	
7a. BIRTHPLACE (State or foreign country) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY		Md			
10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MONTGOMERY GENERAL HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BURTONSVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 14605 DOWLING DRIVE			
14. FATHER'S NAME SAMUEL		First DUVALL		Middle 		Last 		15. MOTHER'S MAIDEN NAME MARY		First PERRY	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. 577-48-1453		17. INFORMANT MEDICAL RECORDS		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma of right breast & pulmonary DUE TO, OR AS A CONSEQUENCE OF (c) metastases										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 10 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 11		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Jan , 1968, to March , 1968, that (I) (we) last saw the deceased alive on 3/15 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE A. Dement Bonifant		DEGREE 		ATTENDING PHYS <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) A. DEMENT BONIFANT, M.D.		22e. ADDRESS MEDICAL CTR. SANDY SPRING, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Mar 18, 1968		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion		23d. LOCATION (City or Town) (County) (State) Bethesda Montgomery Md.					
24. FUNERAL DIRECTOR Jos. Gawler's Sons		ADDRESS 5130 Wisconsin Ave. N.W.		25a. REC'D BY REGISTRAR DATE MAR 21 1968		25b. REGISTRAR'S SIGNATURE James J. Jones					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <i>William Lukens Edwards</i>			2a. DATE OF DEATH Month <i>March</i> Day <i>9</i> Year <i>68</i>			2b. HOUR <i>5:20 P.M.</i>	
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>Sept. 3-1890</i>		6. AGE (In years lost birthday) <i>77</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) <i>Retired - Engineer</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>DC</i>		13b. COUNTY <i>Washington</i>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>3209 Jaclyn St</i>	
14. FATHER'S NAME First <i>Robert</i> Middle <i>Edwards</i> Last <i>Edwards</i>			15. MOTHER'S MAIDEN NAME First <i>Emily</i> Middle <i>Lukens</i> Last <i>Lukens</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>yes</i> (If yes give war or dates of service) <i>-1918</i>			16b. SOCIAL SECURITY NO. <i>577-58 334</i>		17. INFORMANT <i>Undersherman - 3904 Aspen St - Washington</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pneumonia, acute, bronchitis, alveolar</i>							<i>48 hrs</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myelogenous Leukemia, acute</i>							<i>One week</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>1948</i> , to <i>3-9-68</i> , that (I) (we) last saw the deceased alive on <i>March 9, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Stewart Clapp M.D.</i> DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>3-9-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Stewart Clapp MD</i>				22e. ADDRESS <i>4940 Chevy Chase Dr - Chevy Chase Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3-13-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Prince George County, Md.</i>	
24. FUNERAL DIRECTOR <i>Robert A. Humphrey</i>				ADDRESS <i>Bethesda, Md.</i>		25a. REC'D BY REG. STRAR DATE <i>MAR 14 1968</i>	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

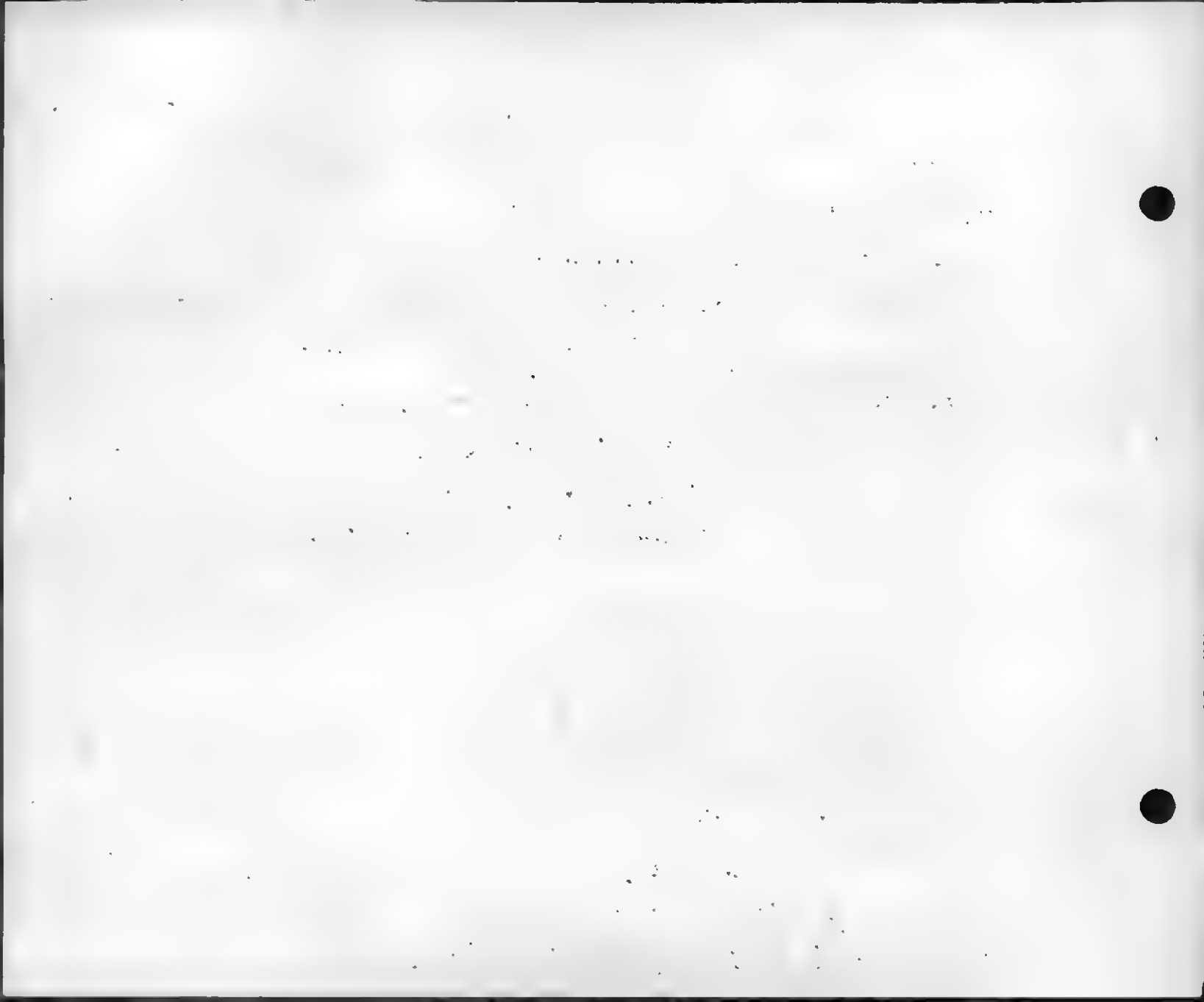


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Vergie May Elliott			2a. DATE OF DEATH Month March Day 12 Year 1968		2b. HOUR 3:34
3 SEX Female	4 RACE White	5. DATE OF BIRTH July 5, 1887		6. AGE (In years lost birthday) 80 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? America	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md		
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince George	13c. CITY OR TOWN Hyattsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2403 University Blvd
14. FATHER'S NAME First Middle Last Kaibfloss		15. MOTHER'S MAIDEN NAME First Middle Last NOT AVAILABLE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO 215-14-6541A		17. INFORMANT Patient's chart	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral anoxia 4330 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Basilar artery thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis - hypertension					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hr. 1 mo. 10 yrs.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (this hospital) attended the deceased from 2-5 , 19 68 to 3-12 , 19 68 , that (we) last saw the deceased alive on 3-11 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.					
22b. SIGNATURE R.D. Bauer, M.D.		MD DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-12-68	
22d. PHYSICIAN'S NAME (Type) R.D. BAUER, M.D.		22e. ADDRESS 2513 Buckle Rd. Catonsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE March 15, 1968		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	
23d. LOCATION (City or Town) (County) (State) Hagerstown Md		23e. REC'D BY REGISTRAR DATE MAR 14 1968			
24. FUNERAL DIRECTOR Walter Walters		25a. REGISTRAR'S SIGNATURE Walter Walters			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last Richard Franklin ELLISON JR.			2a DATE OF DEATH Month MAR Day 29 Year 68		2b HOUR 9:45A
3 SEX Male	4 RACE Caucasian	5. DATE OF BIRTH 15 FEB 68		6 AGE (In years lost birthday) YRS. MONTHS DAYS 1 15	IF UNDER 24 HRS HOURS MIN 15
7a BIRTHPLACE (State or foreign country) Maryland	7b CITIZEN OF WHAT COUNTRY? United States	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	
12b KIND OF BUSINESS OR INDUSTRY		Md			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland 13b COUNTY Prince George's		13c CITY OR TOWN Landover	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 8122 Allendale Dr.	
14. FATHER'S NAME First Middle Last Richard Franklin ELLISON SR			15 MOTHER'S MAIDEN NAME First Middle Last Mabel McKinley HEILIGER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no NA (If yes, give year or dates of service) NA		16b SOCIAL SECURITY NO NA		17 INFORMANT Address Landover, Md. Richard Ellison, SR., 8122 Allendale Drive,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis, diffuse bilaterally 4x6x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 492x					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 15 FEB , 19 68 , to 29 MAR , 19 68 , that (I) (we) last saw the deceased alive on 29 MAR , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <i>G. P. Swartz</i>		DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED 1 April 1968	
22d. PHYSICIAN'S NAME (Type) G. P. SWARTZ, M.D.		22e ADDRESS NAVAL HOSPITAL, BETHESDA, MD.			
23a BURIAL, CREMATION, BOWLING, ETC.		23b DATE 4-3-68		23c NAME OF CEMETERY OR CREMATORY Loudon Park National Cemetery, Baltimore, Md.	
23d LOCATION (City or Town) (County) (State)					
24 FUNERAL DIRECTOR Robert A. Pumphrey		ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		25a. REC'D BY REGISTRAR DATE APR 2 - 1968	
25b. REGISTRAR'S SIGNATURE <i>William Judge</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M I
Checked with Dr. John Ball, Mont. Co. Coroner

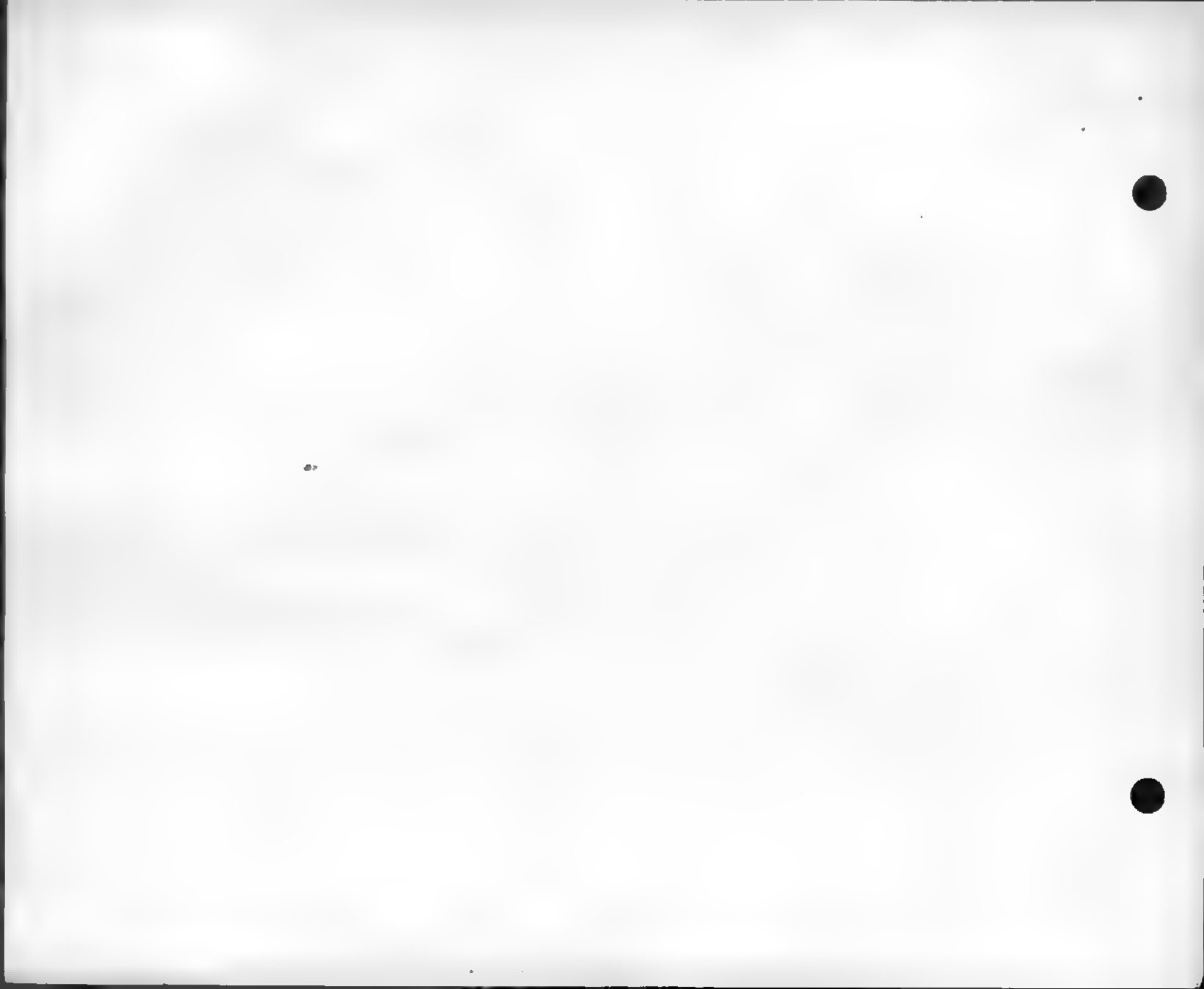
04306

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04294

1. DECEASED-NAME (Type or print) <i>Lottie E. Embrey</i>			2a. DATE OF DEATH Month <i>March</i> Day <i>22</i> Year <i>1968</i>			2b. HOUR <i>7:42</i> P.M.	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>May 5, 1891</i>		6. AGE (In years lost birthday) <i>77</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Rockville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Home maker</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before adm. ssion) STATE <i>Md.</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>4507-Bayne St.</i>		14. FATHER'S NAME First Middle Last <i>Louis Belandier</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>UNKNOWN</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. <i>260</i>		17. INFORMANT <i>Harry Embrey Jr. Son in law</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> 412.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>arteriosclerotic cardiovascular disease 17yr</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Essential hypertension</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>5 years</i>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Central thrombosis</i>							
19a. DATE OF OPERATION <i>-</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>NONE</i>			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>May</i> , 1962 to <i>March 22</i> , 1968, that (I) (we) last saw the deceased alive on <i>March 9</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Stephen C. Cromwell MD</i>				22c. DATE SIGNED <i>3/23/68</i>		22d. PHYSICIAN'S NAME (Type) <i>Stephen C. Cromwell, MD</i>	
22e. ADDRESS <i>615 W. Montgomery Ave. Rockville, Md</i>							
23a. BURIAL CREMATION <i>Burial</i>		23b. DATE <i>3/26/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville, Maryland</i>	
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i>				25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
ADDRESS <i>1331 Rockville Rockville, Md.</i>				DATE <i>MAR 26 1968</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

Item 3 Film G399 1/17/68
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04304

CERTIFICATE OF DEATH

1293

1. DECEASED NAME (Type or print) <i>Charles Raymond Enright</i>			2a. DATE OF DEATH Month <i>March</i> Day <i>25</i> Year <i>68</i>			2b. HOUR <i>3:22 PM</i>	
3 SEX <i>Male</i>		4 RACE <i>White</i>		5. DATE OF BIRTH <i>9-15-52</i>		6. AGE (In years lost birthday) <i>82</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>212-W 4th Montgomery</i>		14. FATHER'S NAME First Middle Last <i>Edwin Howard Enright</i>		15. MOTHER'S M A D E N NAME First Middle Last <i>Wilhelmina</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>no</i> (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO <i>212-32 2216A</i>		17. INFORMANT <i>Gladys Ockorn Rockville, Md.</i>		18. ADDRESS <i>212-W 4th Montgomery</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pulmonary infarction</i> <i>1532</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Adenocarcinoma, descending colon</i> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>1532</i>							
19a. DATE OF OPERATION <i>2/23/68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Cancer of colon</i>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED Where <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>2/19, 1968</i> to <i>3/25, 1968</i> , that (I) (we) last saw the deceased alive on <i>3/25</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Daniel Powers M.D.</i>		22c. DATE SIGNED <i>3/26/68</i>		22d. PHYSICIAN'S NAME (Type) <i>DANIEL POWERS M.D.</i>			
22e. ADDRESS <i>50 W. EDMONSTON DR. ROCKVILLE, MD</i>		23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>3/29/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Bosley Cemetery</i>	
23d. LOCATION (City or Town) <i>Butler, Md.</i>		23e. REC'D BY REGISTRAR DATE <i>MAR 29 1968</i>		23f. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		23g. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR <i>J. F. Eline & Sons Reisterstown, Md.</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DOB all notated. Granted permission to issue.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) <i>Michael Goggin Emery</i>						2a. DATE OF DEATH <i>3</i> Month <i>27</i> Day <i>1968</i>		2b. HOUR <i>20</i> M	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>1/27/1947</i>		6. AGE (In years last birthday) <i>21</i> YRS		7. IF UNDER 1 YEAR MONTHS <i>21</i> DAYS <i>0</i> IF UNDER 24 HRS. HOURS <i>0</i> MIN <i>0</i>	
7a. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md			
10. CITY OR TOWN OF DEATH <i>Rockville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>1129 Parrish Dr.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Biological aid</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>NEH</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>1129 Parrish Drive</i>	
14. FATHER'S NAME First <i>Clarence Eugene</i> Middle <i>Emery</i> Last <i>Emery</i>				15. MOTHER'S MAIDEN NAME First <i>Lena</i> Middle <i>Virginia</i> Last <i>Goggin</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <i>219-48-6161</i>		17. INFORMANT <i>Mother 1129 Parrish Drive.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> <i>75333</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <i>7572</i> (b) <i>Congenital Defects Kidneys</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i> <i>Lifelong</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION <i>1963</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Separation kidneys</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF N.J.R.Y. HOUR <i>AM</i> Month <i>3</i> Day <i>26</i> Year <i>1968</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. <i>at work</i>		21f. LOCATION Street or RFD No _____ City or Town _____ County _____ State _____					
22a. I certify that (I) (this hospital) attended the deceased from <i>3/23/68</i> 19 <i>68</i> to <i>3/26</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>3/23/68</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Earle B. Thompson</i> MD DEGREE				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>3/26/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Earle B. Thompson MD</i>				22e. ADDRESS <i>2121 Pa. Av. NW, Wash., DC.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3/29/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Fort Hill</i>		23d. LOCATION (City or Town) <i>Lynchburg</i> (County) _____ (State) <i>Virginia</i>			
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home Rockville, Md.</i>				25a. REC'D BY REGISTRAR <i>1100 28 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



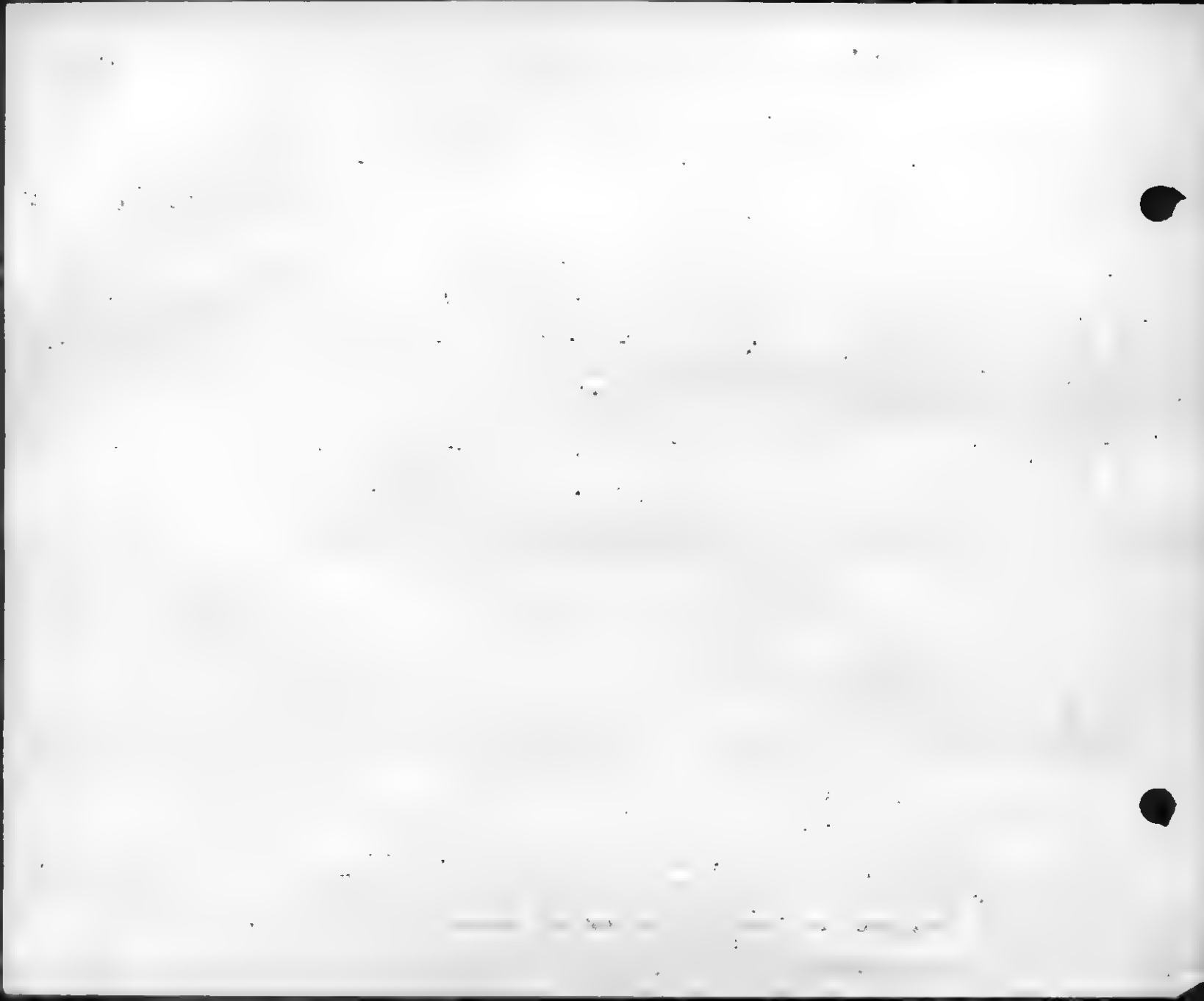
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A75 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last Richard A. ERTZMAN			2a DATE OF DEATH 3 Month 8 Day 68 Year		2b HOUR 8:45 PM
3 SEX Male	4 RACE White	5. DATE OF BIRTH 12/23/16		6 AGE (In years lost birthday) 51 YRS	IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) PA.	7b. CITIZEN OF WHAT COUNTRY? MONT. USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH U.S.A. Montgomery, Md.		
10. CITY OR TOWN OF DEATH Silver Spring, Md	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp		12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired) TEACHER	12b KIND OF BUSINESS OR INDJSTRY —	
13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Md.	13b. COUNTY MONT	13c. CITY OR TOWN Silver Spring	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 15210 Loyhill Rd.	
14. FATHER'S NAME First Middle Last FRED W ERTZMAN		15. MOTHER'S MAIDEN NAME First Middle Last Blanche B. Blanchard HAMMOND			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No		16b SOCIAL SECURITY NO 167 01 0643	17 INFORMANT Address HAMMOND		
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia (pneumonia)</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Multiple Myeloma</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks 4 years.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
22. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from January, 1967, to March 8, 1968, that (I) (we) last saw the deceased alive on March 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature]		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED March 9, 1968	
22d. PHYSICIAN'S NAME (Type) BLAINE H LEIG		22e ADDRESS 9801 Georgia Ave Silver Spring			
23a BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 3-9-68		23c. NAME OF CEMETERY OR CREMATORY GEORGETOWN MED. SCHOOL	
23d. LOCATION (City or Town) (County) (State) WASHINGTON, D.C.					
24. FUNERAL DIRECTOR James C. [Signature] - Wash D.C.		25a. REC'D BY REGISTRAR DATE 14 1968		25b. REGISTRAR'S SIGNATURE [Signature]	



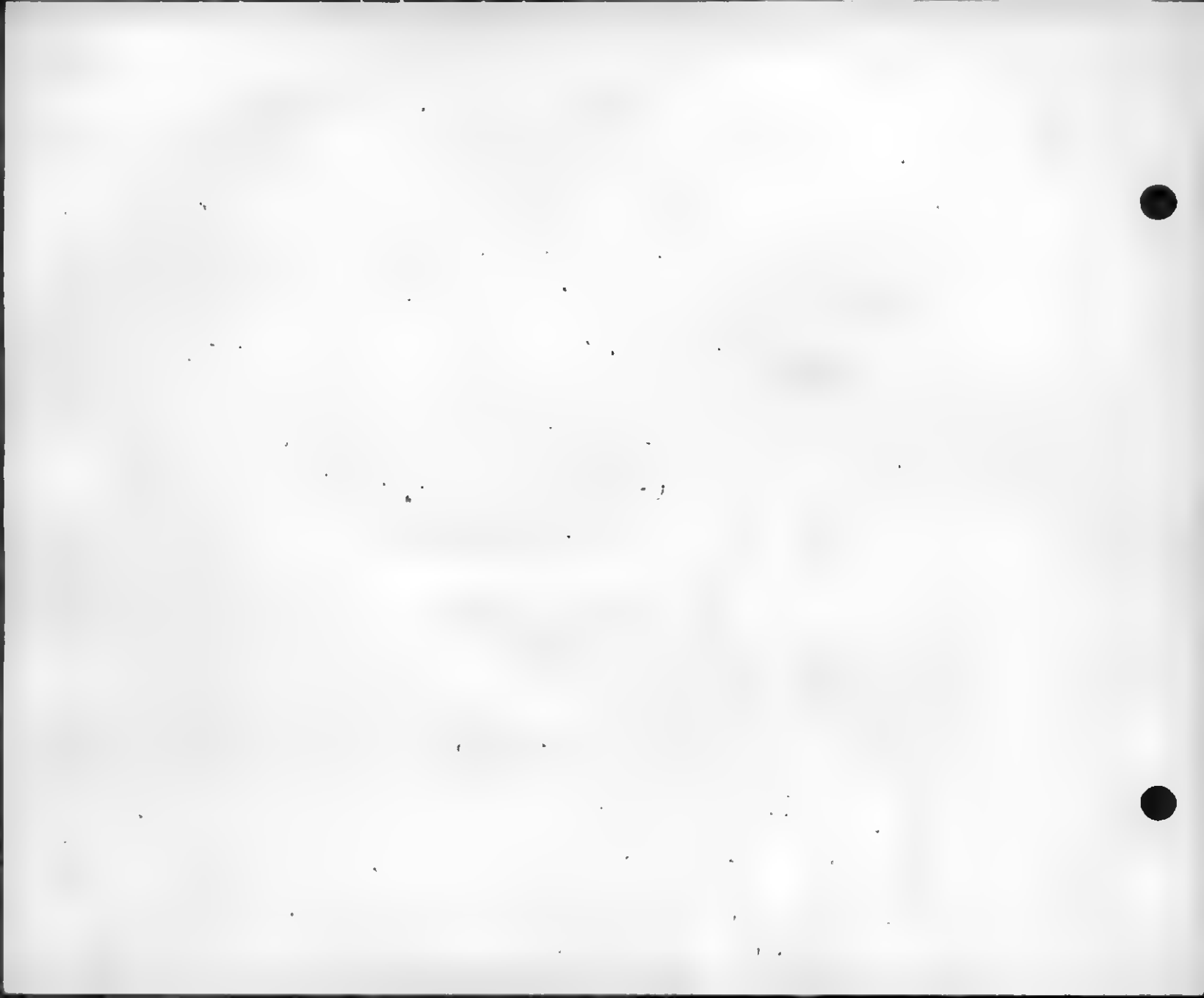
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 1 Film G399 1/11/68 vk
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) EFFIE			First EFFIE Middle FULTZ Last EVANS			2a. DATE OF DEATH Month MARCH Day 8 Year 68			2b. HOUR 8:30 AM																	
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH 4-21-97			6. AGE (In years last birthday) 70 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN 			IF UNDER 24 HRS HOURS MIN 											
7a. BIRTHPLACE (State or foreign country) WEST VA.			7b. CITIZEN OF WHAT COUNTRY? AMERICA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH MONTGOMERY Md.																	
10. CITY OR TOWN OF DEATH TAKOMA PARK			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON SAN. HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) GOVERNMENT			12b. KIND OF BUSINESS OR INDUSTRY																	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE MARYLAND			13b. COUNTY PRINCE GEORGES			13c. CITY OR TOWN RIVERDALE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 4512 Shenandoah street														
14. FATHER'S NAME First Charles Middle MMN Last FULTZ			15. MOTHER'S MAIDEN NAME First ANNA Middle MMN Last STONE			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)							16b. SOCIAL SECURITY NO.							17. INFORMANT Address HOSPITAL RECORDS, TAKOMA PARK MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY: 2509 IMMEDIATE CAUSE (a) Uremia DUE TO, OR AS A CONSEQUENCE OF (b) Acute pyelonephritis DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus																										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DOX																										
19a. DATE OF OPERATION DOX			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. 			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																				
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21a. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State 																				
22a. I certify that (I) (this hospital) attended the deceased from Feb 28, 1968 to March 8, 1968 , that (I) (we) last saw the deceased alive on 3-8-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																										
22b. SIGNATURE Boris Rabkin, M.D. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>															22c. DATE SIGNED 3-9-68											
22d. PHYSICIAN'S NAME (Type) BORIS RABKIN, M.D.															22e. ADDRESS 1019 Univ Blvd, East											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE March 11, 1968			23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Suitland Pro Geo Md.																	
24. FUNERAL DIRECTOR F. Gasch's Sons			ADDRESS Hyattsville Md.			25a. REC'D BY REGISTRAR DATE MAR 12 1968			25b. REGISTRAR'S SIGNATURE Charles Jones																	



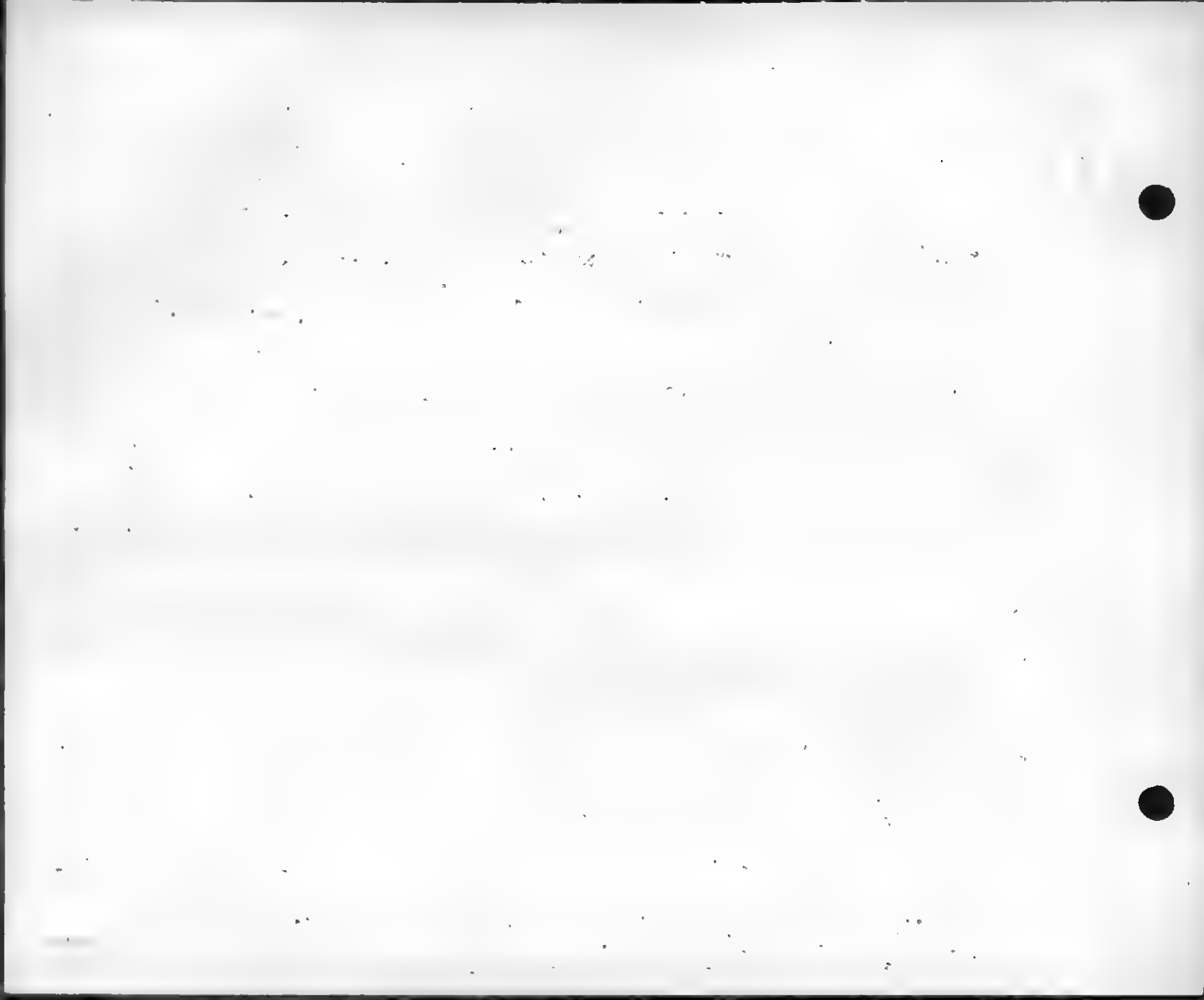
Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
30M REV 1

Charged with Dr. Cullen Reep Medical Examiner on March 26, 1968

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Edward		Middle M		Last Linch		2a. DATE OF DEATH Month March Day 26 Year 1968		2b. HOUR 11:12 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH March 12, 1903		6. AGE (In years last birthday) 65 YRS.		F UNDER 1 YEAR MONTHS DAYS 	
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanatorium		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired florist		12b. KIND OF BUSINESS OR INDUSTRY Local			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Hillandale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 10610 Greenacres Drive	
14. FATHER'S NAME First Unknown Middle Last 		15. MOTHER'S MAIDEN NAME First Unknown Middle Last 							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 577-09-0524		17. INFORMANT Edith L. Linch		Address 10610 Greenacres Drive Hillandale, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery myocardial infarction 4129 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last None APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH records since Nov 2, 1954 Unknown								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) None	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. 		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State 					
22a. I certify that (I) (this hospital) attended the deceased from March 7, 1950 , to March 26, 1968 , that (I) (we) last saw the deceased alive on March 6, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Aaron H. Traumm MD DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED March 27, 1968					
22d. PHYSICIAN'S NAME (Type) Aaron H. Traumm				22e. ADDRESS 8237 Georgia Ave. Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE March 27, 1968		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland			
24. FUNERAL DIRECTOR Charles J. Humphrey, Inc. Silver Spring, Md.				25a. REC'D BY REGISTRAR DATE MAR 29 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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04312
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) MAE W FINCH			2a. DATE OF DEATH Month MARCH Day 31 Year 68			2b. HOUR 4A M	
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH 12-12-1885		6. AGE (In years last birthday) 82 YRS.	
7a. BIRTHPLACE (State or foreign country) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY —	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND		13b. COUNTY Montgomery		13c. CITY OR TOWN CHEVYCHASE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 4000 VIRGILIA ST		14. FATHER'S NAME First JOHN Middle N. Last WRIGHT		15. MOTHER'S MAIDEN NAME First FANNIE Middle HUGHES Last HARRISON		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO		17. INFORMANT George A FINCH JR.		Address 4000 VIRGILIA ST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarct, acute 410.9 DUE TO, OR AS A CONSEQUENCE OF (b) Caloric cardiac stenosis DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis							years years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Infarction of Small intestine; Diabetes mellitus							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1969 , 19 March 31 , 19 68 , that (I) (we) last saw the deceased alive on March 31 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert N. Coale M.D.		22c. DATE SIGNED March 31, 1968		22d. PHYSICIAN'S NAME (Type) ROBERT N. COALE		22e. ADDRESS 4429 Bradley Lane, Chevy Chase Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-3-68		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D. C.	
24. FUNERAL DIRECTOR R.A. Pennington		ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	

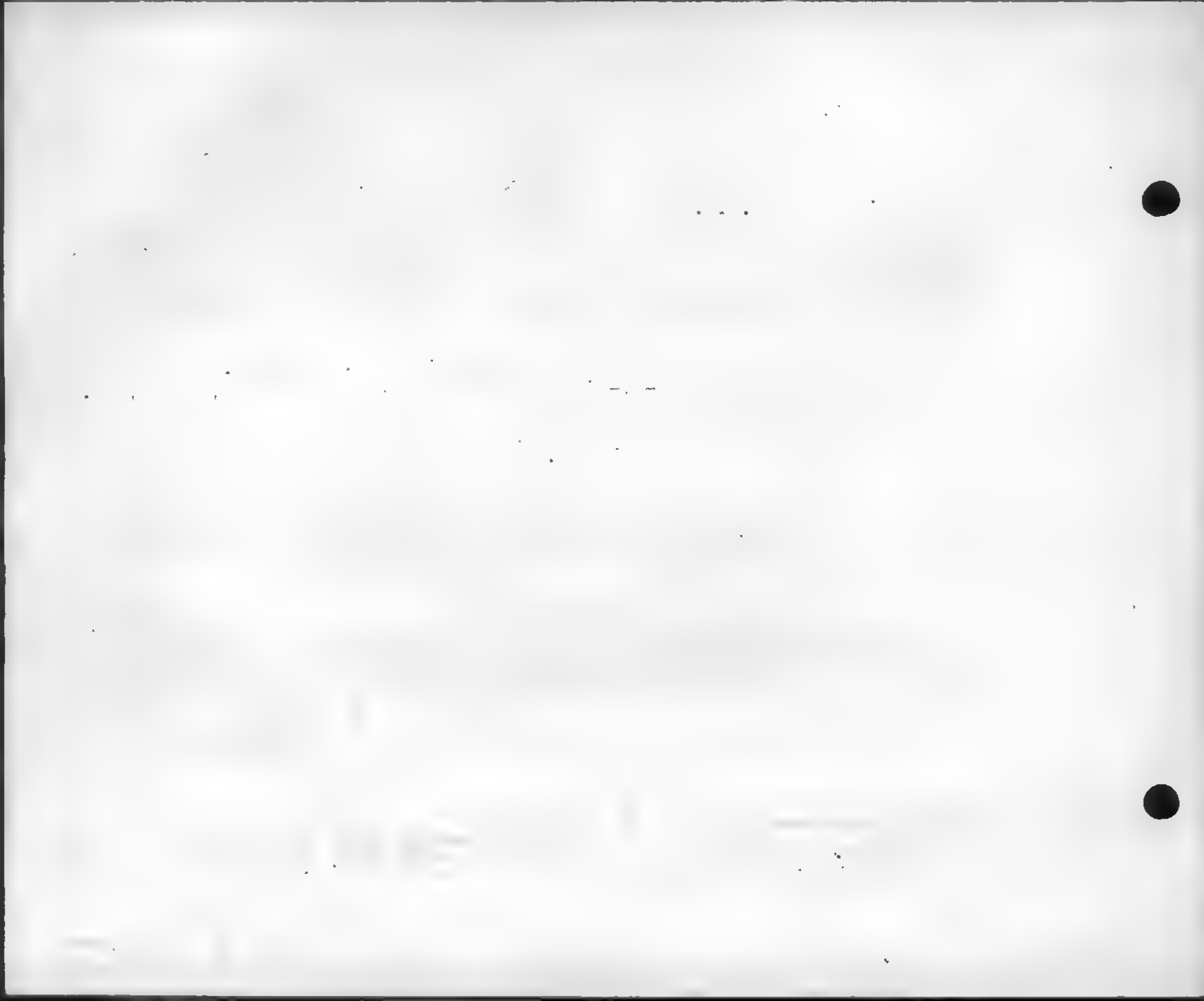


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR
Milton			Rodger Fisher			Month Day Year			M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	F UNDER 1 YEAR MONTHS DAYS		F UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD	2d HOUR
male	white	2/12/69	59 YRS					Month Day Year	M
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			Md.
Maryland		U.S.A.				Montgomery			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY
Olney			Montgomery General			Salesman			Pillsbury
13a U.S.A. RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b. COUNTY			13c CITY OR TOWN		3d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Maryland			Baltimore			Catonsville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	221 Edridge Way
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
Thomas Fisher			Schlitz						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			
no			213-05-4756			Medical Records Dept. Montgomery General Hospital, Olney, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Massive Coronary</u> 410.9 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF <u>Coronary Artery Heart Disease</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION									20 AUTOPSY?
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
			19						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State				
22a I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER						
BELDEN R. REAP, M.D.			DEPUTY MEDICAL EXAMINER						
			ADDRESS (Street, City, Town, or County)						
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL			4-4-1968		Woodlawn Cemetery		Woodlawn, Maryland		
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Howard H. Hubbard, 4107 Wilkens Ave.			21229			DATE APR 3 - 1968		Charles Judge	



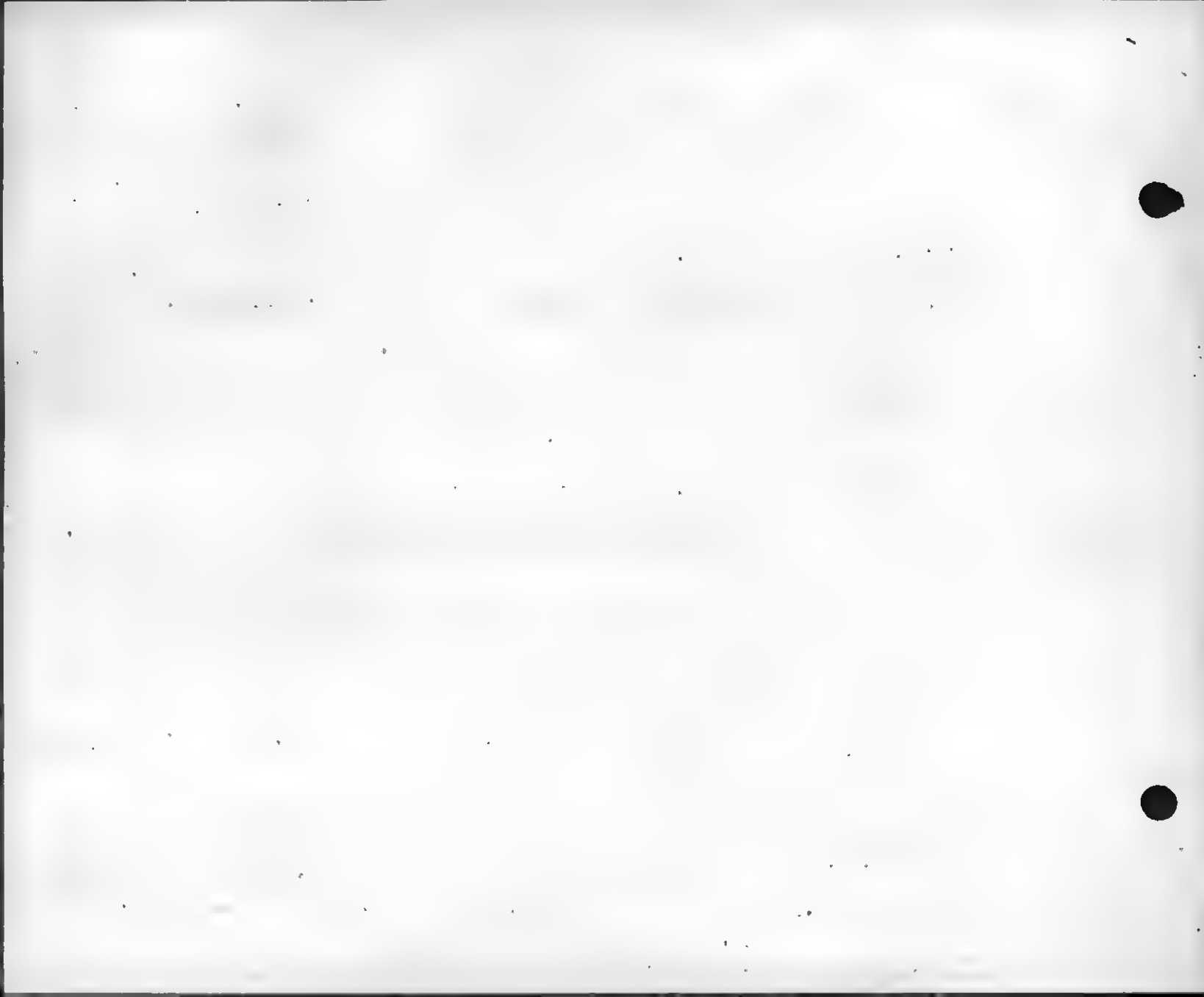
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

431
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

4300

1. DECEASED-NAME (Type or print) First Middle Last STEPHEN NMN FLANAGAN			2a. DATE OF DEATH Month Day Year MARCH 15 1968		2b. HOUR 8:32 PM
3. SEX MALE		4. RACE CAUC		5. DATE OF BIRTH 9 FEB 68	
7a. BIRTHPLACE (State or foreign country) FLA		7b. CIT ZEN OF WHAT COUNTRY? USA		6. AGE (In years last birthday) YRS MONTHS DAYS 35 1 35	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVAL HOSPITAL		9. COUNTY OF DEATH MONTGOMERY Md.	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE FLA		13b. COUNTY ESCAMBIA		13c. CITY OR TOWN PENSACOLA	
13d. INSIDE CITY (L.M.T.S.P.) YES		13e. STREET AND NUMBER 216 KALASH RD.		12b. KIND OF BUSINESS OR INDUSTRY	
14. FATHER'S NAME First Middle Last RAYMOND A FLANAGAN			15. MOTHER'S MAIDEN NAME First Middle Last ELLEN WHALEN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address RAYMOND A FLANAGAN 216 KALASH RD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory arrest 746.0 DUE TO, OR AS A CONSEQUENCE OF (b) congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Congenital heart disease; tetralogy of fallot; inter-atrial septal defect PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) septal defect					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21f. LOCATION Street or R.F.D. No. City or Town County State	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (this hospital) attended the deceased from Feb. 27 , 19 68 , to March 15 , 19 68 , that (I) (we) lost saw the deceased alive on March 15 , 19 68 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>[Signature]</i>				22c. DATE SIGNED Mar 18, 1968	
22d. PHYSICIAN'S NAME (Type) F. X. LOEB, M. D.				22e. ADDRESS Naval Hospital, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-20-68		23c. NAME OF CEMETERY OR CREMATORY Barrancas National Cemetery Pensacola, Florida	
23d. LOCATION (City or Town) (County) (State) (County) (State)		24. FUNERAL DIRECTOR Robert A. Pumphrey 7557 Wisconsin Ave., Bethesda, Md.			
25a. REC'D BY REGISTRAR MAR 26 1968		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD-310 1-7-71 at
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) William H. Ford Sr.			2a DATE OF DEATH March Month 15 Day 1968			2b HOUR 1:40		
3 SEX Male		4 RACE White		5. DATE OF BIRTH April 9, 1881			6. AGE (In years lost birthday) 86 YRS.	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U S		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md		
10 CITY OR TOWN OF DEATH Silver Spring			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Colonial Villa Nurs. Home			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) U.S. Post Off.		
13a USUAL RESIDENCE (Where deceased lived if institution: Residence before death) 409 16th St., S.E.			13b COUNTY D.C.		13c CITY OR TOWN Washington		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 409 16th Street, S.E.			14. FATHER'S NAME First Middle Last William H. Ford			15 MOTHER'S MAIDEN NAME First Middle Last Rachel Ann Mamie Nelson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. XXXX-66-5517-T			17 INFORMANT Address Nursing Home Records-12325 N. Hamp. Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Diffuse bronchopneumonia (bilateral) 112.7 DUE TO, OR AS A CONSEQUENCE OF Severe advanced arterio-sclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4501 DUE TO, OR AS A CONSEQUENCE OF Severely PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Esophageal stricture; arterio-sclerotic heart disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State		
22a I certify that (I) (this hospital) attended the deceased from 12-20, 1967 to 3-15, 1968 , that (I) (we) last saw the deceased alive on 3-13-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE Herbert S. Gates DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						22c DATE SIGNED 3-15-68		
22d. PHYSICIAN'S NAME (Type) HERBERT S. GATES						22e. ADDRESS 819 - EAST CAPITOL ST.		
23a BURIAL, CREMATION REMOVAL (Specify) Burial			23b. DATE Mar. 18, 1968		23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		23d. LOCATION (City or Town) (County) (State) Cristfield, Somerset, Md.	
24 FUNERAL DIRECTOR Lee Fun. Home 300 4th St. NE Wash., D.C.						25a. REC'D BY REGISTRAR DATE MAR 21 1968		25b. REGISTRAR'S SIGNATURE [Signature]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

VR A15 (4)
304A REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
Items#13c,e Film#G399 1/1/68 km 04816		1. DECEASED NAME (Type or print) <i>Anne</i> First Middle Last <i>Frye</i>						2a. DATE OF DEATH 3 Month 19 Day Year 68		2b. HOUR 8:15 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 5-20-1885		6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS 9 DAYS 29		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1115 Parish Drive			
14. FATHER'S NAME Jesse First Middle Last		15. MOTHER'S MAIDEN NAME Jane First Middle Last Adams									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 22-70-8603		17. INFORMANT Hospital records Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cardiac Failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Sever. Dehydration +</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Emaciation</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>7016</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <i>3-17-68</i> , 19 <i>68</i> , to <i>3-18-68</i> , 19 <i>68</i> . That (I) (we) lost saw the deceased alive on <i>3-18-68</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Milton D. Westberg M.D.</i>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>3-20-68</i>	
22d. PHYSICIAN'S NAME (Type) Milton Westberg		22e. ADDRESS 431 N. Frederick Ave.		Gaithersburg, Md.							
23a. BURIAL CREMATION, REMOVAL (Type)		23b. DATE 3/23/68		23c. NAME OF CEMETERY OR CREMATORY Lutheran Church Cem.		23d. LOCATION (City or Town) Lovettville		(County) Virginia		(State)	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		ADDRESS 1331 Rock. Pike		25a. REC'D BY REGISTRAR DATE MAR 26 1968		25b. REGISTRAR'S SIGNATURE <i>Judge</i>					
Rockville, Maryland											

MEDICAL CERTIFICATION

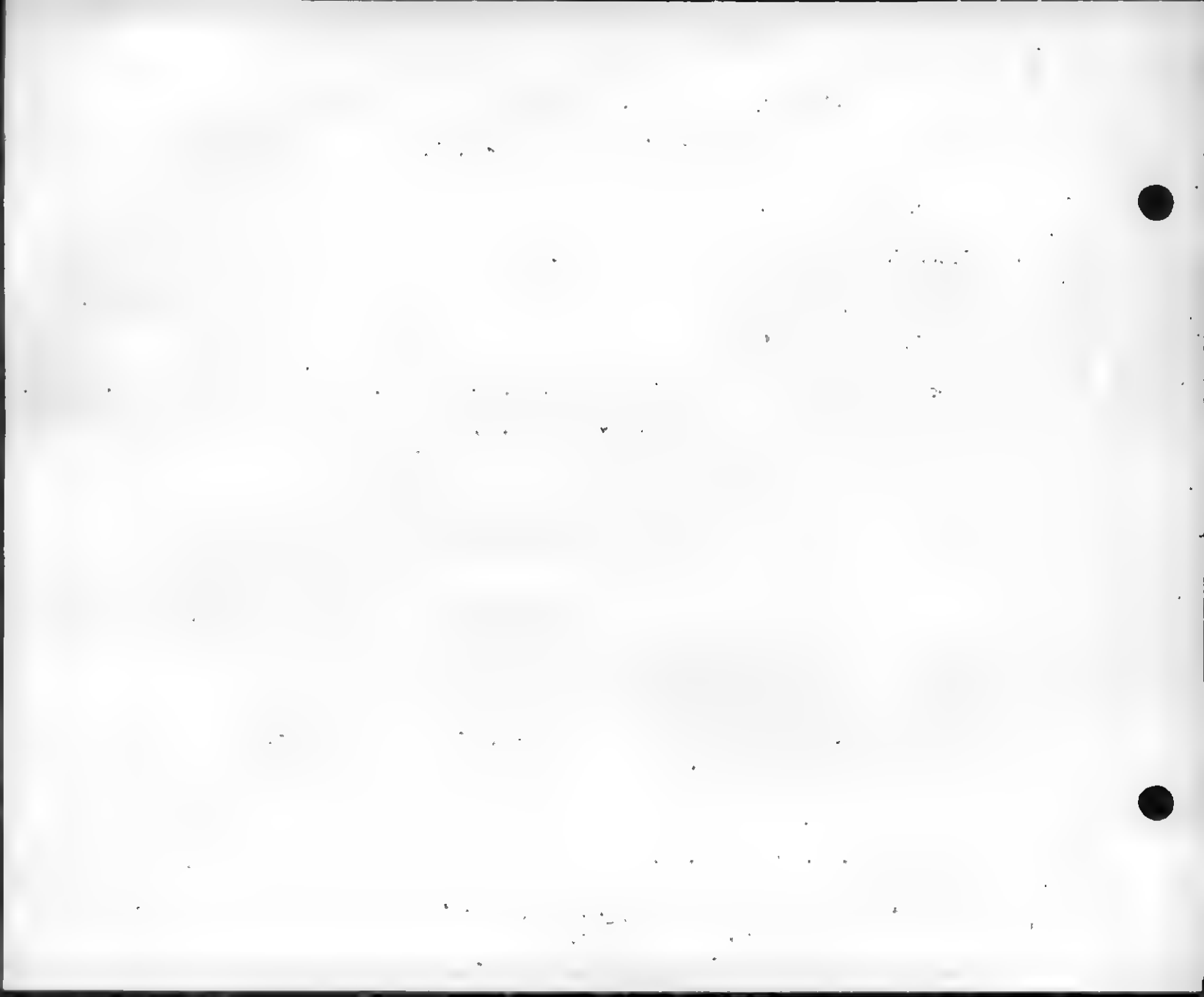


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Williamina		First M.		Middle GARDNER		Last		20. DATE OF DEATH March Month 21 Day 1968		26. HOUR 900A M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH Oct. 5, 1891		6. AGE (In years last birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Scotland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY N/A					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virginia		13b. COUNTY Burke		13c. CITY OR TOWN Burke		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 9624 Burke View Ave.			
14. FATHER'S NAME First William		Middle Mitchell		Last		15. MOTHER'S MAIDEN NAME First Isabell Taylor		Middle Burke, Va.		Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown <input type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 024-16-8643		17. INFORMANT Mr. William E. Gardner, 9624 Burke View Ave.		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Adenocarcinoma of the stomach with metastases 101.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that he (this hospital) attended the deceased from Mar. 20 , 19 68 , to Mar. 21 , 19 68 , that he (we) last saw the deceased alive on Mar. 21 , 19 68 , and that in our (our) opinion death occurred on the date and hour and from the causes stated above, he (we) (did) (did not) view the body after death.											
22b. SIGNATURE W. J. Fouty, M. D.								DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 21 March 1968	
22d. PHYSICIAN'S NAME (Type) W. J. Fouty, M. D.								22e. ADDRESS Naval Hospital, Bethesda, Maryland			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE 3/24/68		23c. NAME OF CEMETERY OR CREMATORY Howard Street Cem.		23d. LOCATION (City or Town) (County) (State) Northboro, Massachusetts					
24. FUNERAL DIRECTOR Falls Church Funeral Home 1102 West Broad Street, Falls Church, Va.						25a. REC'D BY REGISTRAR MAR 26 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



CERTIFICATE OF DEATH

14304

1. DECEASED NAME (Type or print) ^{First} <i>Ella</i> ^{Middle} <i>May</i> ^{Last} <i>Mass</i>			2a. DATE OF DEATH <i>March</i> ^{Month} <i>6</i> ^{Day} <i>1968</i> ^{Year}		2b. HOUR <i>8:45 PM</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>MAY 17, 1886</i>		6. AGE (In years last birthday) <i>81</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i> Md		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>St. Elizabeth's</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired</i>	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>	13b. COUNTY <i>St. Mary's</i>	13c. CITY OR TOWN <i>COLTON POINT</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER	
14. FATHER'S NAME ^{First} <i>William Edward</i> ^{Middle} <i>Cullins</i> ^{Last}	15. MOTHER'S MAIDEN NAME ^{First} <i>MARY</i> ^{Middle} <i>ELIZABETH</i> ^{Last} <i>RUSSELL</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)	16b. SOCIAL SECURITY NO. <i>4127</i>	17. INFORMANT <i>Mr. S. S. Wade - 4516</i> Address <i>Montgomery - Chapel</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> <i>4127</i> DUE TO, OR AS A CONSEQUENCE OF <i>Myocarditis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF <i>Arteriosclerotic Heart Disease</i> (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4127</i>					
19a. DATE OF OPERATION		19b. COMBINATION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY <i>5-4</i> ^{HOUR} <i>PM</i> ^{Month} <i>Day <i>Year</i> <i>1968</i></i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) <i>Office Building etc</i>		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>5-4</i> , 19 <i>68</i> , to <i>3-6</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>3-6</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour noted from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>W. Clarke Mattingley M.D.</i>		22c. DATE SIGNED <i>3-6-68</i>		22d. PHYSICIAN'S NAME (Type)	
22e. ADDRESS		22f. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>MARCH 9, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>SACRED HEART CEMETERY</i>	
23d. LOCATION (City or Town) <i>BUSHWOOD</i>		(County) <i>ST. MARY'S</i>		(State) <i>MARYLAND</i>	
24. FUNERAL DIRECTOR <i>W. CLARKE MATTINGLEY</i>		ADDRESS <i>LEONARDTOWN, MARYLAND</i>		25a. REC'D BY REGISTRAR <i>MAR 8 1968</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



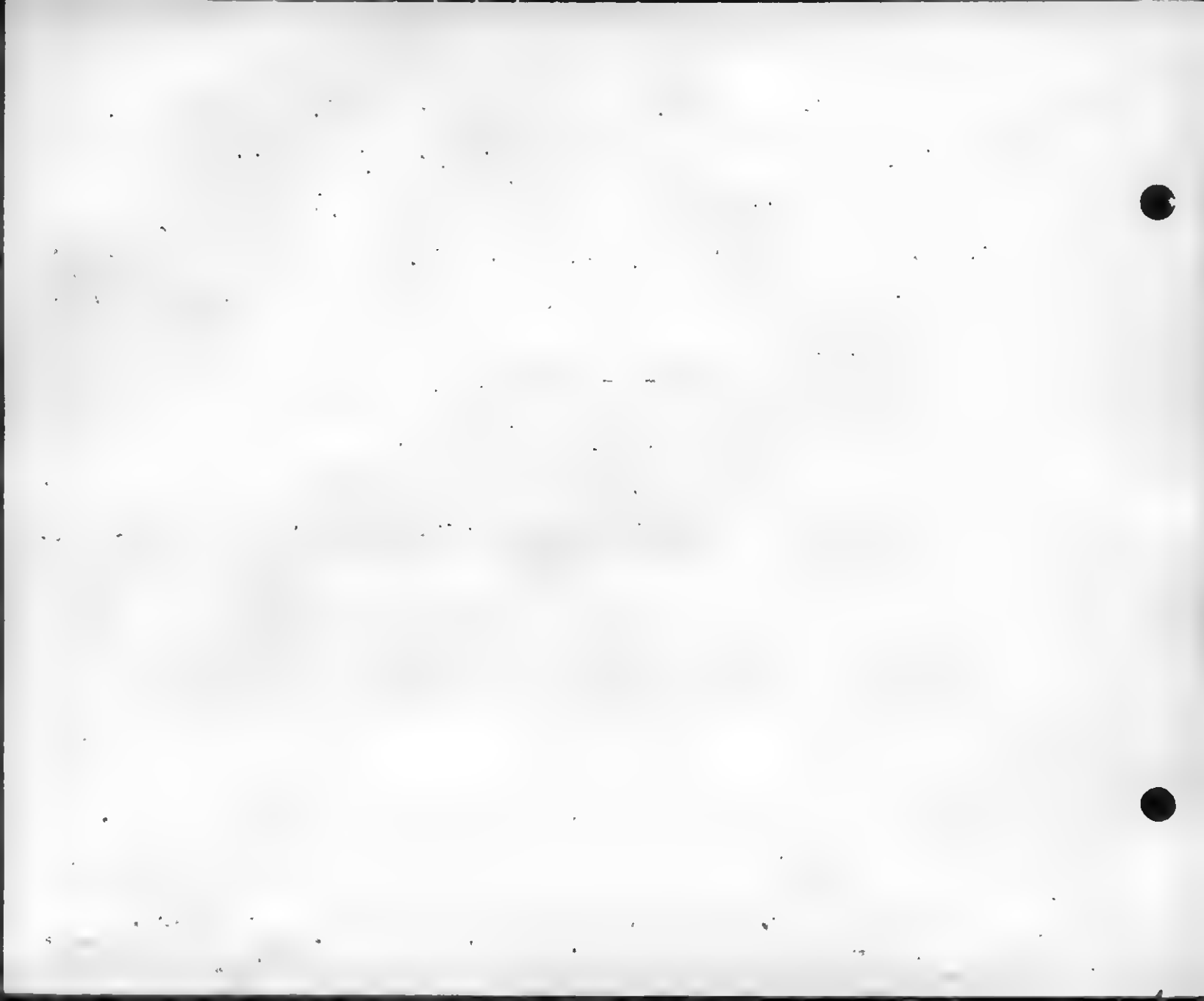
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician only, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 M
30A REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

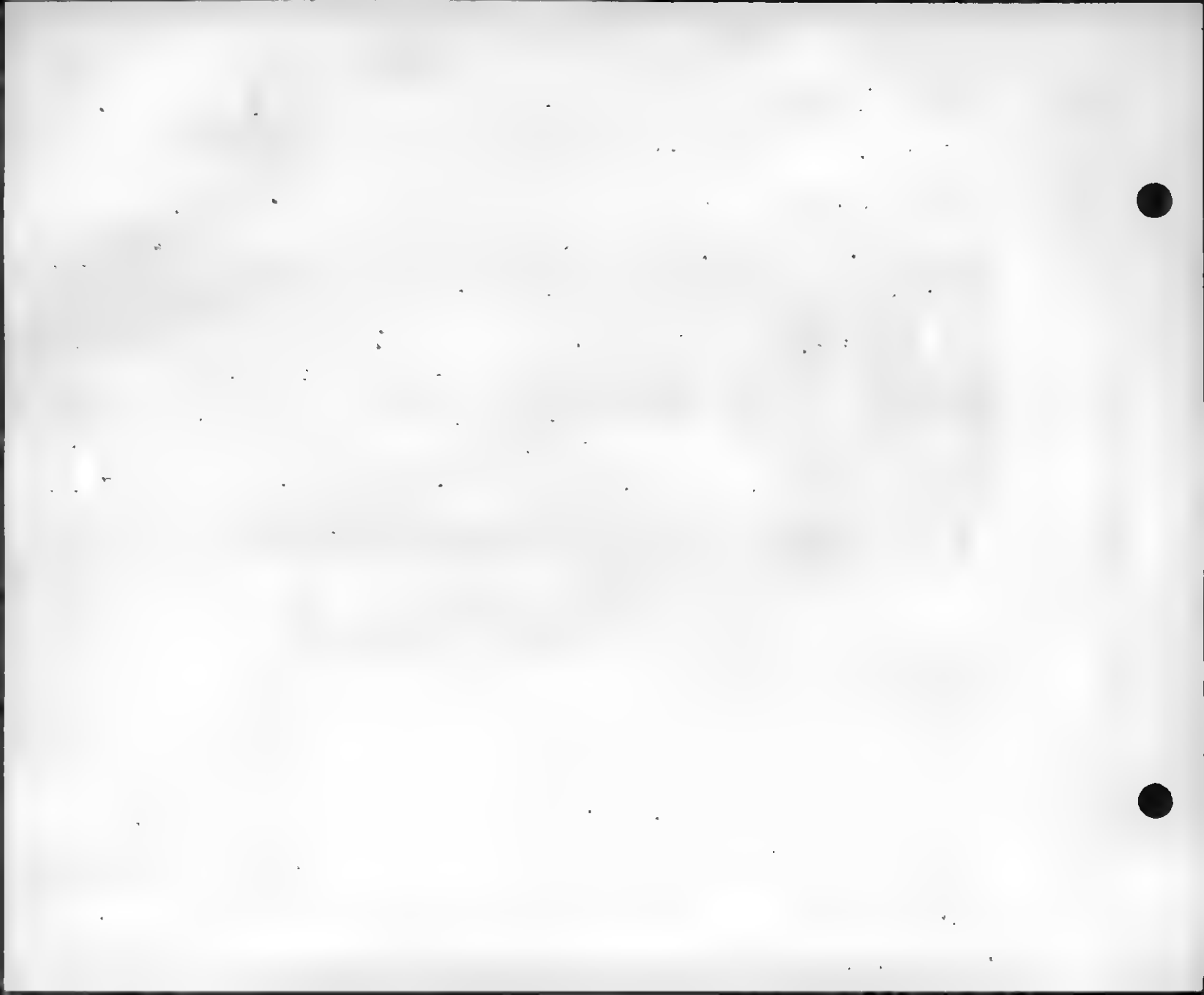
1. DECEASED-NAME (Type or print) First Middle Last Walter Andrew Gentner			2a. DATE OF DEATH Month Day Year March 26 1968		2b. HOUR 2:30 P.M.
3 SEX Male	4 RACE white	5. DATE OF BIRTH 9-30-89		6. AGE (In years lost birthday) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) D. C.	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium & Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired	12b. KIND OF BUSINESS OR INDUSTRY Suppliers	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13b. COUNTY Prince Georges	13c. CITY OR TOWN Lewisdale	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2232 Chapman Road	
14. FATHER'S NAME First Middle Last John Gentner		15. MOTHER'S MAIDEN NAME First Middle Last Mary Newman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 577-10-0277		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation DUE TO, OR AS A CONSEQUENCE OF (b) acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic cardiovascular disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 mins 72 hrs 20+ yrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4261					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from August 1961, to March 26, 1968, that (I) (we) last saw the deceased alive on March 26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert A. McCormick MD DEGREE				22c. DATE SIGNED 3/26/68	
22d. PHYSICIAN'S NAME (Type) Robert A. McCormick				22e. ADDRESS 4316 Clagett Rd. Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/29/68		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	
23d. LOCATION (City or Town) Colmar Manor, Md.		23e. LOCATION (County) Prince Georges		23f. LOCATION (State) Md.	
24. FUNERAL DIRECTOR Valley's Funeral Home Inc.				25a. REC'D BY REGISTRAR DATE APR 1, 1968	
25b. REGISTRAR'S SIGNATURE James J. Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) GERTRUDE First NOKE Middle GERBER Last						2a. DATE OF DEATH Month March Day 6 Year 1968			2b. HOUR 8:00 AM		
3 SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH 8/12/18		6 AGE (In years last birthday) 49 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN 	
7a BIRTHPLACE (State or foreign country) PENNSYLVANIA		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.					
10 CITY OR TOWN OF DEATH TAKOMA PARK		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON SAN. HOSP.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SECRETARY		12b KIND OF BUSINESS OR INDUSTRY SECY-UNIV. of MARYLAND					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND				13b COUNTY HYATTSVILLE		13c CITY OR TOWN HYATTSVILLE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 6700 BEACREST Rd.	
14. FATHER'S NAME First HERMAN Middle HURSHMAN Last				15 MOTHER'S MAIDEN NAME First SYLVIA Middle GOTTLIEB Last							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b SOCIAL SECURITY NO. 160-16-7489		17 INFORMANT HOSPITAL RECORDS		Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 1744V CARDIAC FAILURE 3 WEEKS											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) CHEMOTHERAPY FOR METASTATIC CARCINOMA 7 YEARS											
(c) CARCINOMA OF LEFT BREAST 12 YEARS											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 170X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from JULY, 1953 to MARCH 6, 1968 , that (I) (we) last saw the deceased alive on MARCH 6, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert L. Krichmar M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED MARCH 6 1					
22d. PHYSICIAN'S NAME (Type) ROBERT L. KRICHMAR M.D.						22e. ADDRESS 7733 ALASKA AVENUE N.W. WASHINGTON DC 20012					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-8-68		23c. NAME OF CEMETERY OR CREMATORY Degel Israel Cemetery		23d. LOCATION (City or Town) Lancaster (County) Pa. (State)					
24. FUNERAL DIRECTOR Donald M. Stein ADDRESS 232 Carroll St., NW, Wash., D.C.				25a. REC'D BY REGISTRAR Charles Judge DATE MAR 11 1968		25b. REGISTRAR'S SIGNATURE					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, and in any event, within 72 hours after death should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) PATRICK MALCOM GIBBONS		2a. DATE OF DEATH Month 10 Day 68 Year		2b. HOUR M
3 SEX MALE	4 RACE CAUCASIAN	5. DATE OF BIRTH March 8, 1968	6 AGE (In years last birthday) YRS	IF UNDER 1 YEAR MONTHS 2 DAYS
7a BIRTHPLACE (State or foreign country) MARYLAND	7b CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY COUNTY Md.	
10. CITY OR TOWN OF DEATH BETHESDA	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) US NAVAL HOSPITAL	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND	13b COUNTY MONTGOMERY	13c CITY OR TOWN BETHESDA	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER WISCONSIN AVE.
14. FATHER'S NAME First Middle Last JOSEPH M GIBBONS	15. MOTHER'S MAIDEN NAME First Middle Last AGNES E SWITZER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, (unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address Md. JOSEPH M. GIBBONS, 57083 Forest Rd., Cheverly		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis 4 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from March 8, 1968 , to March 10, 1968 , that (I) (we) last saw the deceased alive on March 10, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (do not) view the body after death.				
22b. SIGNATURE <i>G. P. Swartz</i>		DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22c. DATE SIGNED 11 March 1968	
22d. PHYSICIAN'S NAME (Type) G. P. SWARTZ, M. D.		22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 3-15-68	23c. NAME OF CEMETERY OR CREMATORY Grandview, St. Joseph Division, McKeesport, Penn.	23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home		25a. REC'D BY REGISTRAR DATE MAR 15 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
25c. ADDRESS 7557 Wisconsin Ave., Bethesda, Md.				



FOR STATE HEALTH DEPT.

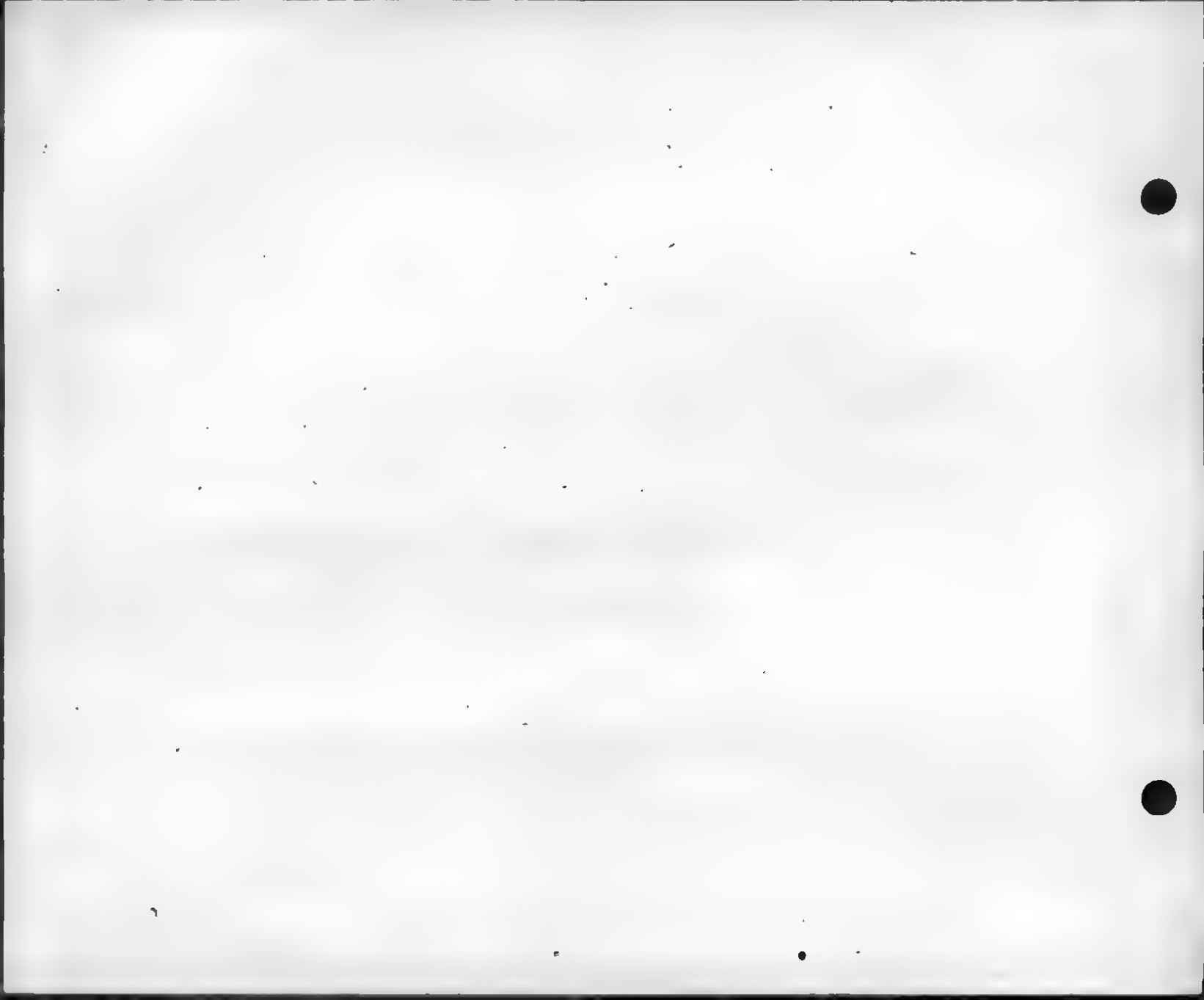
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) MILES HENRY GIBBS			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 3 Day 30 Year 1968			2b. HOUR 4:50 M P			
3. SEX M	4. RACE Cauc	5. DATE OF BIRTH 9/19/37	6. AGE (in years last birthday) 30 YRS	7. UNDER YEAR MONTHS 3 DAYS 30	8. IF UNDER 24 HRS HOURS 3 MIN 30	2c. DATE PRONOUNCED DEAD Month 3 Day 30 Year 1968			
7a. BIRTHPLACE (State or foreign country) Missouri		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md			
10. CITY OR TOWN OF DEATH Whites Ferry		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Potomac River		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) Wash. D.C. Dept. of Health		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE VA.				13b. CITY OR TOWN ARLINGTON ARL.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER 2517-N. 20th ROAD	
14. FATHER'S NAME First Collier Middle Gibbs Last Gibbs				15. MOTHER'S MAIDEN NAME First Helen Middle Capehart Last Capehart					
16a. WAS DECEASED EVER U.S. ARMED FORCES? (Yes, initial unknown) Unknown		16b. SOCIAL SECURITY NO 570-48-8230		17. INFORMANT Every Funeral Home Records		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Drowned in attempting to DUE TO, OR AS A CONSEQUENCE OF 1109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Rescue son in Potomac River (b) Rescue son in Potomac River DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month Day, Year 3-30-68 HOUR A.M. 3:30 P.M. 3:30		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 2 Item 18) Rescue son drowned while trying to save son			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Potomac River		21f. LOCATION Street or P.D. No 1 mi. N. of Whites Ferry City or Town Montgomery County MD. State MD.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Belden R. Keap M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 3/30/1968	
EXAMINER'S NAME (Type) BELDEN R. KEAP M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
				ADDRESS (If not deputy, town or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 4, 1968		23c. NAME OF CEMETERY OR CREMATORY Stonewall Memory Gardens		23d. LOCATION (City or Town) Manassas, Virginia (County) (State)			
24. FUNERAL DIRECTOR Every Funeral Home				ADDRESS Fairfax, Virginia		25a. REC'D BY REGISTRAR APR 5 - 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

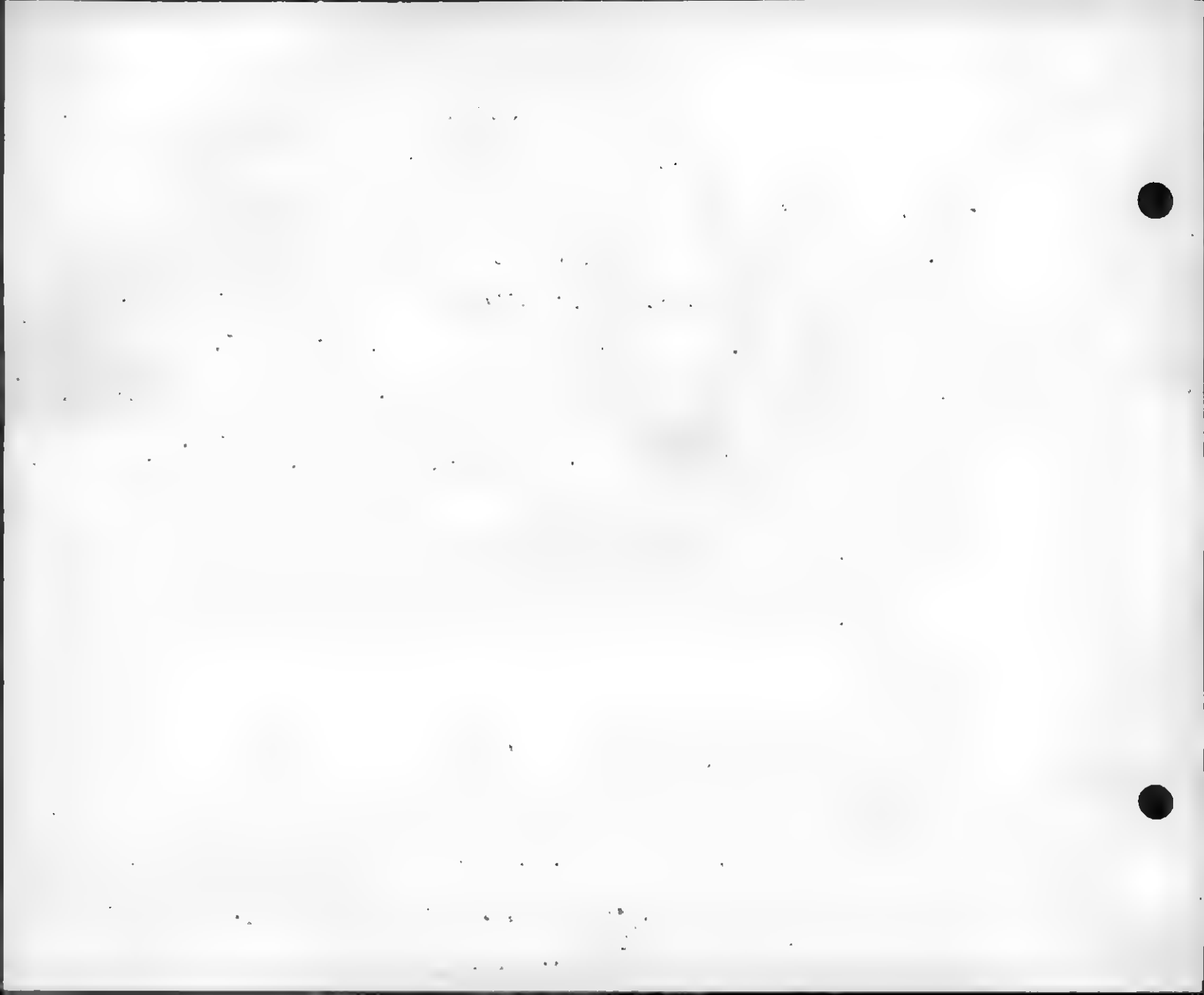


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH													
1. DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR A M		
Kathy			Lee		GIBSON		March 17		68		1:00		
3 SEX		4 RACE		5 DATE OF BIRTH				6 AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
Female		Caucasian		March 17, 1968				YRS				36	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Bethesda, Maryland			USA					Montgomery Md					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda			Naval Hospital				N/A			N/A			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
Maryland			Montgomery		Rockville				205 England Terr.				
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME First Middle Last				
Terry L. Gibson									Carolyn F. Sarber				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17 INFORMANT			Address 205 England Terr.				
No			N/A			Carolyn F. Gibson			Rockville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Congenital anomaly; sequester lobe left lung, DUE TO, OR AS A CONSEQUENCE OF with massive atelectasis of lungs bilaterally Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 7592													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)				21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 17 March, 1968, to 17 March, 1968, that (I) (we) last saw the deceased alive on 17 March 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Jerry J. Tomasovic								DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 21 March 1968	
22d. PHYSICIAN'S NAME (Type) Jerry J. Tomasovic, M. D.								22e. ADDRESS Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			3/22/68		Arlington National Cemetery, Arlington, Virginia								
24. FUNERAL DIRECTOR Tyson-Wheeler Funeral Home								25a. REC'D BY REGISTRAR DATE MAR 26 1968		25b. REGISTRAR'S SIGNATURE			
1331 East Montgomery Ave. Rockville, Md.													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

4324

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <i>JAMES E. GILLIS</i>			2a DATE OF DEATH Month <i>March</i> Day <i>4</i> Year <i>1968</i>			2b HOUR M
3. SEX <i>MALE</i>		4 RACE <i>WHITE</i>		5. DATE OF BIRTH <i>OCT. 15, 1896</i>		6 AGE (In years last birthday) <i>71</i> YRS.
7a BIRTHPLACE (State or foreign country) <i>MAINE</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>MONTGOMERY County Md</i>
10. CITY OR TOWN OF DEATH <i>SILVER SPRING</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>8015 Eastwest Highway</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>C.P.A.</i>		12b KIND OF BUSINESS OR INDUSTRY <i>CPA</i>
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Maryland</i>		13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Silver Spr.</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First <i>Joseph</i> Middle <i>Gillis</i> Last <i>A. Mac CALVIN</i>		15. MOTHER'S MAIDEN NAME First <i>Corinne M. Gillis</i> Middle <i>8604 Sundale Drive</i> Last		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>W.W.T.</i> (If yes give war or dates of service)		
16b. SOCIAL SECURITY NO <i>579-07-0094A</i>		17 INFORMANT <i>Corinne M. Gillis</i> Address <i>Silver Spring, Md</i> <i>8604 Sundale Drive</i>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute pyelonephritis, Chronic pyelonephritis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic pyelonephritis - B.P.N.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes Mellitus</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i> <i>2 years</i> <i>30 years</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Chronic elevatis Hypertension Heart Disease</i>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <i>June</i> , 19 <i>62</i> to <i>March</i> , 19 <i>68</i> , that (I) (<i>we</i>) last saw the deceased alive on <i>29 Feb</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (<i>we</i>) (did) (<i>did not</i>) view the body after death.						
22b SIGNATURE <i>W. Thomas Yeager, Jr.</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED <i>3/1/68</i>
22d PHYSICIAN'S NAME (Type) <i>W. Thomas Yeager, Jr.</i>				22e ADDRESS <i>1808 Conn Ave NW WASH. DC</i>		
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>2-5-68</i>		23c NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven</i>		23d LOCATION (City or Town) (County) (State) <i>Silver Spring Mont. Md.</i>
24. FUNERAL DIRECTOR <i>Francis J. Collins</i>		3821 ADDRESS <i>Wash D.C.</i>		25a. REC'D BY REGISTRAR <i>DAMAR 4 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <i>Eunice Marie Lingall</i>			2a. DATE OF DEATH Month <i>March</i> Day <i>11</i> Year <i>1968</i>			2b. HOUR <i>7:45 PM</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>July 28 - 1905</i>		6. AGE (in years last birthday) <i>62 YRS.</i>	
7a. BIRTHPLACE (State or foreign country) <i>McLean-Va</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Cabin John</i>		13d. RESIDE-CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First <i>Leonard</i> Middle <i>Marble</i> Last <i>Wickley</i>		15. MOTHER'S MAIDEN NAME First <i>Mc</i> Middle <i>Ann</i> Last <i>Smith</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. (If yes give way and dates of service) <i>No 224-03-3894</i>		17. INFORMANT Name <i>Marion Moore</i> - Above Address <i>(Daughter)</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Recurrent Carcinoma of Esophagus</i>							<i>2 MONTHS PLUS</i>
DUE TO, OR AS A CONSEQUENCE OF <i>metastatic to mediastinum and pleura and ribs</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO, OR AS A CONSEQUENCE OF (b) _____							
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>150 v Malignant Pleural Effusion</i>							
19a. DATE OF OPERATION <i>2 YRS AGO</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>CARC. ESOPHAGUS</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR AM _____ Month _____ Day _____ Year _____ P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____			
22a. I certify that (I) (this hospital) attended the deceased from <i>March 1, 1968</i> , to <i>March 11, 1968</i> , that (I) (we) last saw the deceased alive on <i>March 10, 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death							
22b. SIGNATURE <i>J. W. Peabody Jr. MD</i>				22c. DATE SIGNED <i>3-11-68</i>		22d. PHYSICIAN'S NAME (Type) <i>J. W. PEABODY JR MD</i>	
22e. ADDRESS <i>8512 Old Georgetown Rd. Bethesda, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>3-16-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>MT ZION CEMETERY</i>		23d. LOCATION (City or Town) <i>BETHESDA MD</i>	
24. FUNERAL DIRECTOR <i>W.W. Cloumen Co</i>				24b. ADDRESS <i>3072 N St NW, D.C.</i>		24c. REC'D BY REGISTRAR <i>DATE MAR 14 1968</i>	
25b. REGISTRAR'S SIGNATURE							



MDARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) JOHN HERMAN GLOVER			2a. DATE OF DEATH Month 1 Day 19 Year 1968			2b. HOUR 2:00 PM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH XXXXXX 8/28/13		6. AGE (In years lost birthday) 54 YRS.		7. UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN		
7a. BIRTHPLACE (State or foreign country) Ala.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) OWNER-OPERATOR			12b. KIND OF BUSINESS OR INDUSTRY STATION SERVICE	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Md.			13b. COUNTY Howard		13c. CITY OR TOWN Jessup, Md		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER RPD#1, Box 207/Mission Rd	
14. FATHER'S NAME First B. G. Middle GLOVER Last				15. MOTHER'S MAIDEN NAME First OMIE Middle KIRK Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 423-01-6109		17. INFORMANT MRS. J. N. GLOVER - ABOVE			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE, RECURRENT MYOCARDIAL INFARCTION 19 DAYS DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) MANIFESTED BY FIRST INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH 19 DAYS APRIL 1966	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) HEAVY CIGARETTE SMOKE POLYCYTHEMIA (TYPE NOT DETER.), MILD and HYPERURICEMIA										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. 19 Month 12 Day 12 Year 1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No 612 MAIN ST. City or Town LAUREL County MD. State MD.				
22a. I certify that (I) (this hospital) attended the deceased from 12 FEB , 19 68 , to 1 MAR , 19 68 , that (I) (we) last saw the deceased alive on 1 MARCH 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Richard Compton M.D.						22c. DATE SIGNED 1 MARCH 68				
22d. PHYSICIAN'S NAME (Type) J. RICHARD COMPTON						22e. ADDRESS 612 MAIN ST., LAUREL, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 3-4-68		23c. NAME OF CEMETERY OR CREMATORY Sanage Cem			23d. LOCATION (City or Town) (County) (State) Sanage Md		
24. FUNERAL DIRECTOR William J. Hunsley Laurel, Md.						25a. REC'D BY REGISTRAR DATE MAR 13 1968		25b. REGISTRAR'S SIGNATURE Charles Jones		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

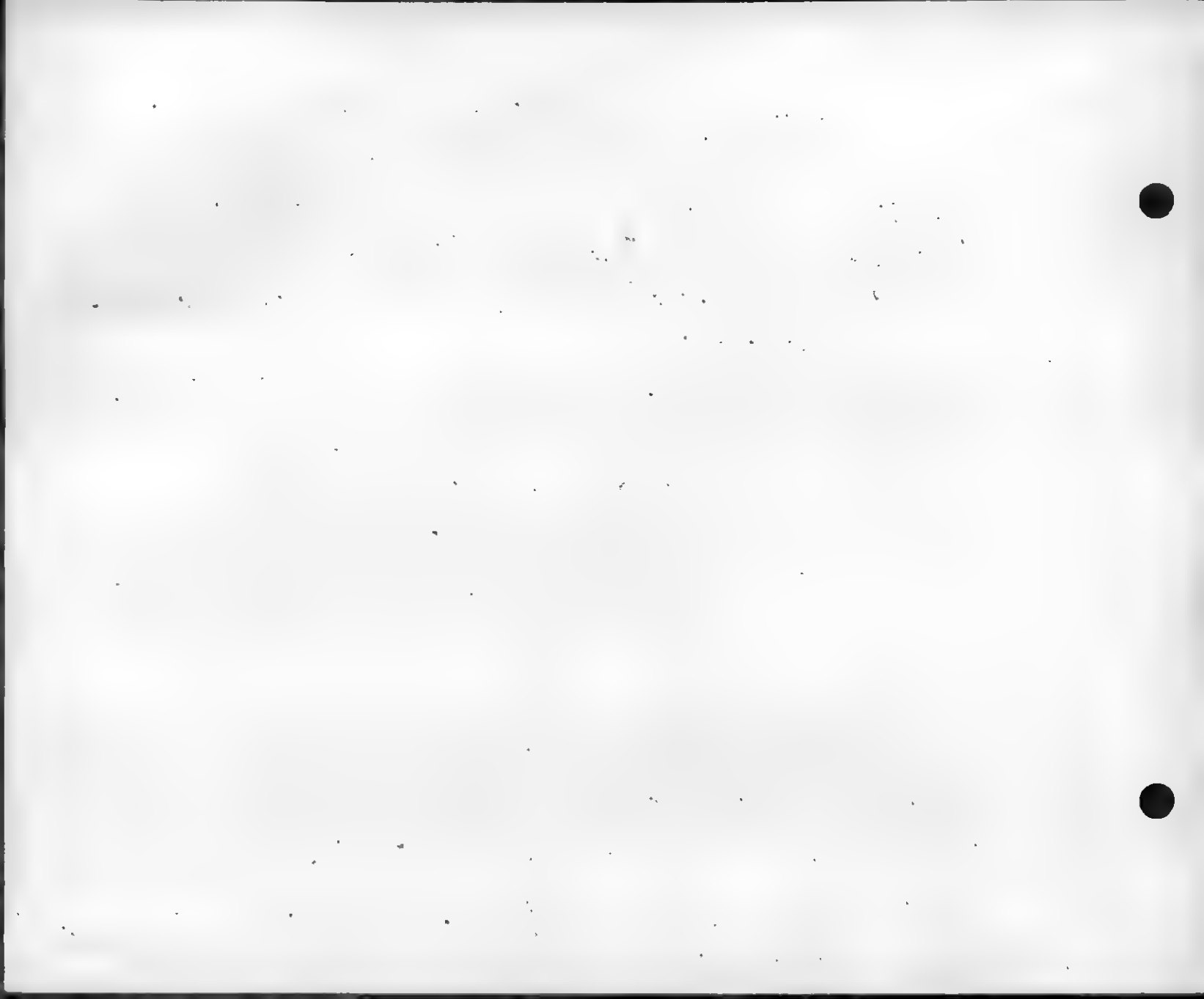
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
300A REV. 1/68

MD 321
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04313

1. DECEASED-NAME (Type or print) LENA		First Middle Last Goldstein		2a. DATE OF DEATH Month 11 Day 68 Year MAR		2b. HOUR 9-45 M.	
3. SEX 7		4. RACE W		5. DATE OF BIRTH '81		6. AGE (in years lost birthday) 97 YRS	
7a. BIRTHPLACE (State or foreign country) Russia		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Fairland Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if ret. red.) HOUSEWIFE		12b. KIND OF BUS. NESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 11235 Oakleaf Dr.		14. FATHER'S NAME First Middle Last UNKNOWN		15. MOTHER'S MA DEN NAME First Middle Last UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. NOUE		17. INFORMANT RUDOLPH GOLDSTEIN		Address 707 11 STREET NEW YORK, N.Y.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Heart Failure, Congestive 428X DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis Generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost +							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Obliterative Vascular Disease - rt leg; Left Pleural effusion							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not wh. e <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from FEB 10 , 19 68 , to 3-11- , 19 68 , that (I) (was) last saw the deceased alive on 3-11- , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Samuel A. Hillman DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c. DATE SIGNED 3-11-68			
22d. PHYSICIAN'S NAME (Type) SAMUEL A. HILLMAN MD.				22e. ADDRESS 8829 FLOWER AVENUE SILVER SPRING, MD. 20901			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3/13/68		23c. NAME OF CEMETERY OR CREMATORY new montefiore		23d. LOCATION (City or Town) (County) (State) Ft. Det.	
24. FUNERAL DIRECTOR CONCEAL FUNERAL HOME		ADDRESS 4217 9th St. N.W.		25a. FILED BY REGISTRAR MAR 14 1968		25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

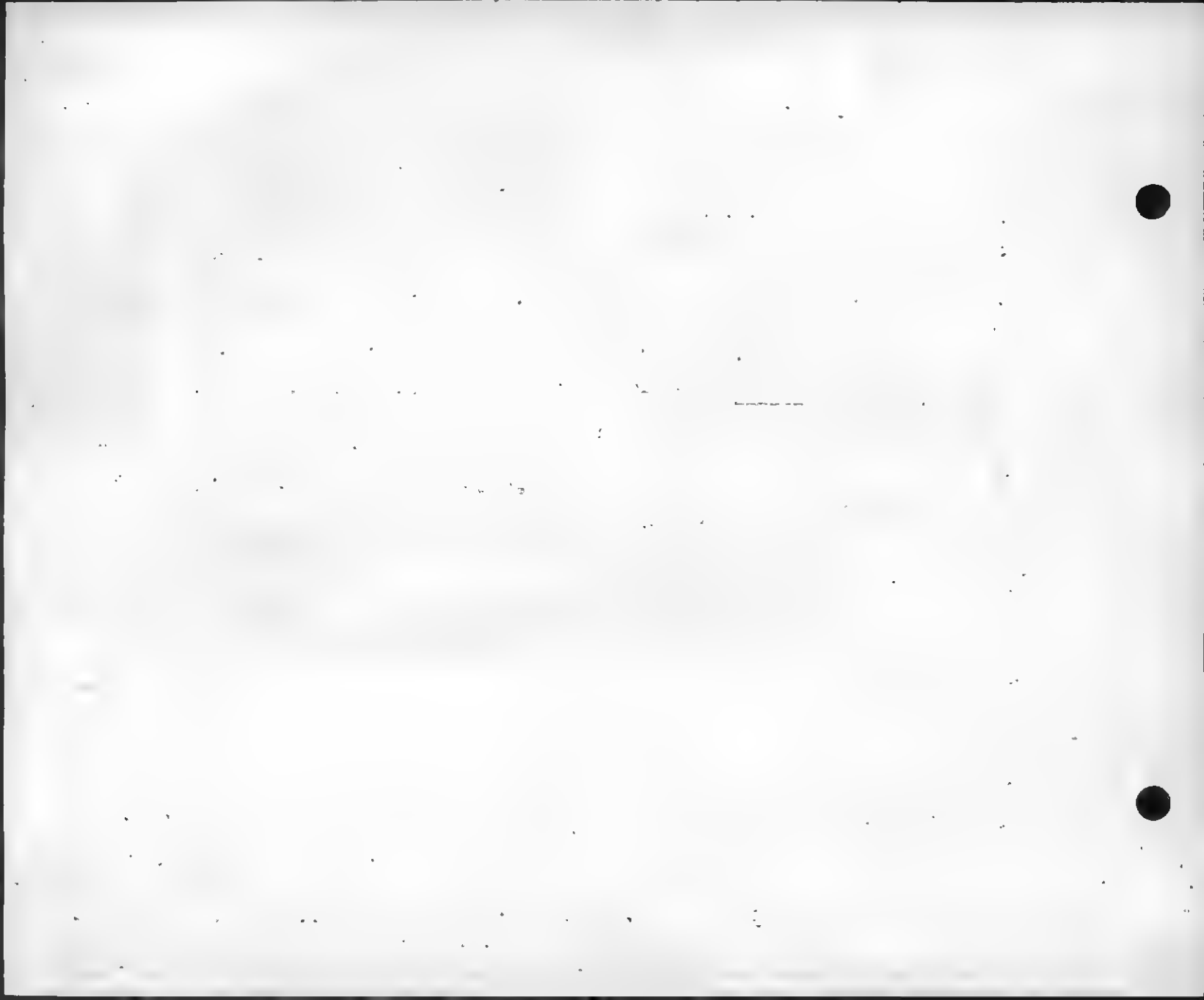
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Medical Examiner - William Kurstin MD

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH				
JAMES			M		GONGWER				Month 3 Day 30 Year 68				
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		2b. HOUR				
Male		White		August 5, 1901			66		10:10 A.M.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
Ohio		U.S.A.				Montgomery							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Rockville			10500 Rockville Pike			Consulting Engineer		Self Employed					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
Maryland			Montgomery		Rockville				10500 Rockville Pike				
14 FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First Middle Last	
Elton			A.		Gongwer				Clara			A. Minnick	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17 INFORMANT			Address				
No			577-09-2378			Genevieve B. Gongwer, Wife, Same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u>										Immed.			
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC CORONARY HEART DISEASE</u>										3-5 yrs			
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTERIOSCLEROSIS</u>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
<u>DIABETES MELLITUS</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
		HOUR A.M. Month Day Year P.M. 19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State			
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>													
22a. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , to <u>3-30, 1968</u> , that (I) (we) last saw the deceased alive on <u>3/23, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE										22c. DATE SIGNED			
<u>William Kurstin MD</u>										<u>3-30-68</u>			
22d. PHYSICIAN'S NAME (Type) <u>William Kurstin</u>										22e. ADDRESS			
										<u>916 19th St. N.W. Wash. DC.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)			
<u>Burial</u>		<u>4/2/68</u>		<u>Parklawn Cemetery</u>		<u>Rockville, Montg., Md.</u>							
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
<u>Joseph Gawler's Sons, Washington, D.C.</u>						<u>APR 5 - 1968</u>		<u>Charles Judge</u>					

MD 1-75 (4)
FORM REV 1/68

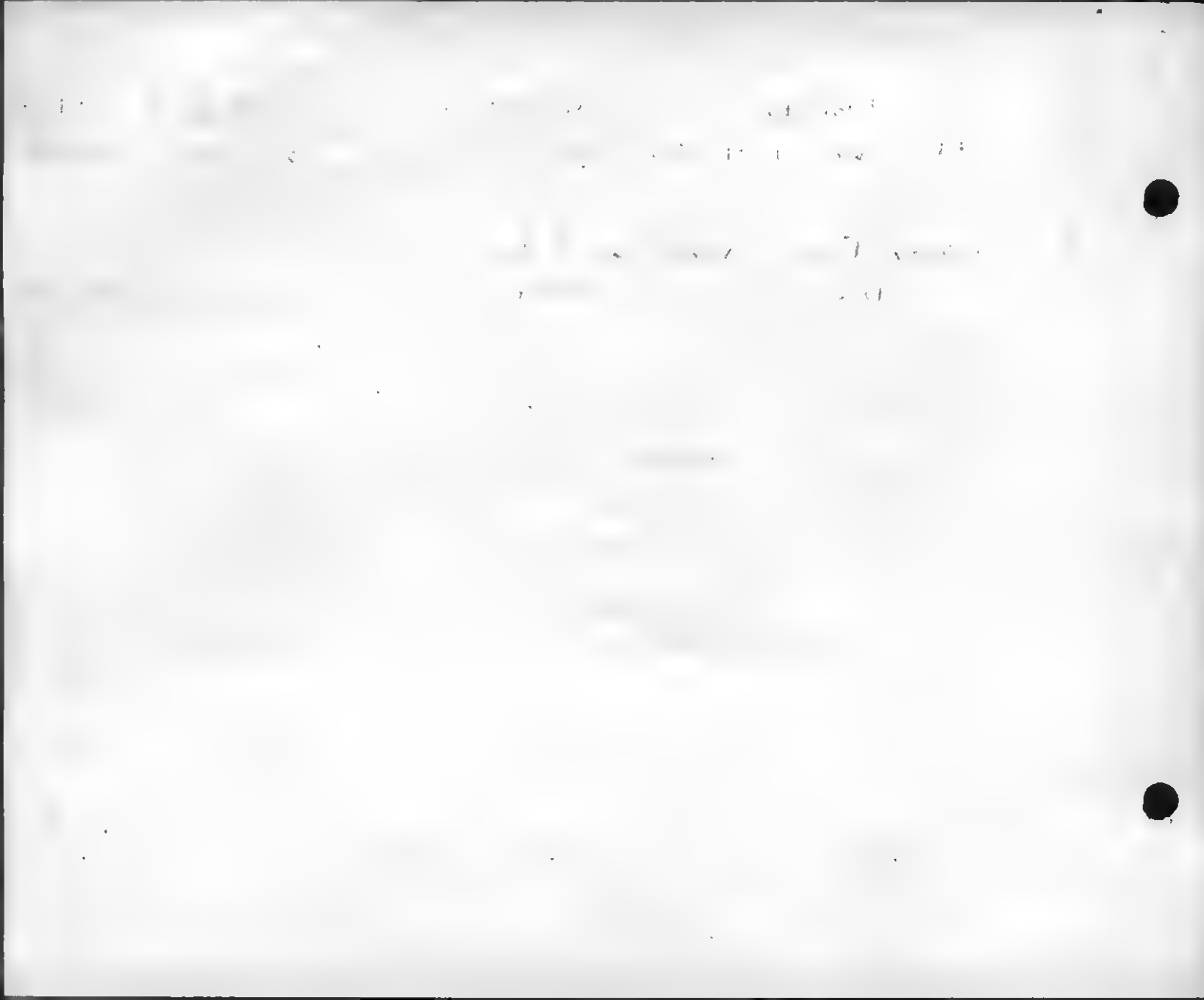


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 903-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
MORRIS			GRAYEFSKY			3-8-1968			12 PM		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 UNDER 1 YEAR	8 UNDER 24 HRS	2c DATE PRONOUNCED DEAD			2d HOUR		
M	W	12-15-89	78 YRS	MONTHS	DAYS	3 8			12 PM		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
RUSSIA			USA			Montgomery			Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
TAKOMA PARK			WASH SAN & HOSP			PAPER HANGING					
13a USJA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INS DE CITY LIMITS?		
D C			V			WASH.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e STREET AND NUMBER			13f		
RAPHAEL GRAYEFSKY			ESTHER MARY			3817 GEORGIA AVE NW.					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			18 ADDRESS		
YES			579-16-4196A			SISTER			38 CROCKET AVENUE		
(If yes give war or dates of service)			WW I			MRS. IDA WELLSON			BROOKLYN - N.Y.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY											
IMMEDIATE CAUSE (a) Acute Coronary Insufficiency											
DUE TO, OR AS A CONSEQUENCE OF											
(b) Arteriosclerotic Heart Disease											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
4											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
				19							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)				21f LOCATION Street or RFD No City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MED CAL EXAMINER				22b DATE SIGNED			
EXAMINER'S NAME (Type)				ASS STANT MED CAL EXAMINER				3/8/1968			
BELDEN R. REAP M.D.				DEPUTY MEDICAL EXAMINER							
				ADDRESS (Street, city, county)							
23a BURIAL CREMATION REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY			
BURIAL				3-13-68				BALTIMORE NATIONAL CEM - BALTIMORE MD			
24 FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR			
BERNARD DANZANSKY & SONS - WASH D C								25b REGISTRAR'S SIGNATURE			
								DATE MAR 14 1968			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

4200

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <u>Carrie Emily Green</u>			2a. DATE OF DEATH Month <u>3</u> Day <u>11</u> Year <u>68</u>			2b. HOUR <u>8 4</u> M					
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>Dec. 23, 1880</u>		6. AGE (In years last birthday) <u>87</u> YRS.		IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u>		IF UNDER 24 HRS HOURS <u> </u> MIN. <u> </u>	
7a. BIRTHPLACE (State or foreign country) <u>Tennessee</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md					
10. CITY OR TOWN OF DEATH <u>Kensington</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Kensington Gardens N. H.</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Housewife</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md.</u>			13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Kensington</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>10547 St. Paul Street</u>		
14. FATHER'S NAME First <u>Thomas</u> Middle <u> </u> Last <u>Givens</u>			15. MOTHER'S MAIDEN NAME First <u>Eleanor</u> Middle <u> </u> Last <u>Anderson</u>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <u>213-56-6970</u>		17. INFORMANT <u>Ellen G. Davis</u> Address <u>10547 St. Paul Street Kensington, Maryland</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular occlusion</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>fractured left femur</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u> </u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>332 X</u> <u>Carcinoma of Breast</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. <u> </u> P.M. <u> </u> Month <u> </u> Day <u> </u> Year <u>19</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. <u> </u> City or Town <u> </u> County <u> </u> State <u> </u>					
22a. I certify that (I) (this hospital) attended the deceased from <u>10/4</u> , 19 <u>60</u> , to <u>3/11</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3/10</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>George Boenig</u> DEGREE <u> </u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <u>3/11/68</u>					
22d. PHYSICIAN'S NAME (Type) <u>George Boenig</u>						22e. ADDRESS <u>5410 Connecticut Avenue, N.W. Wash. D.C.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Interment</u>			23b. DATE <u>March 14, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Willis Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Hancock Co. Tennessee</u>			
24. FUNERAL DIRECTOR <u>Glen Carter</u> <u>James E. Pumphrey, Inc.</u>			25a. REC'D BY REG. STRAR <u>DA MAR 20 1968</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

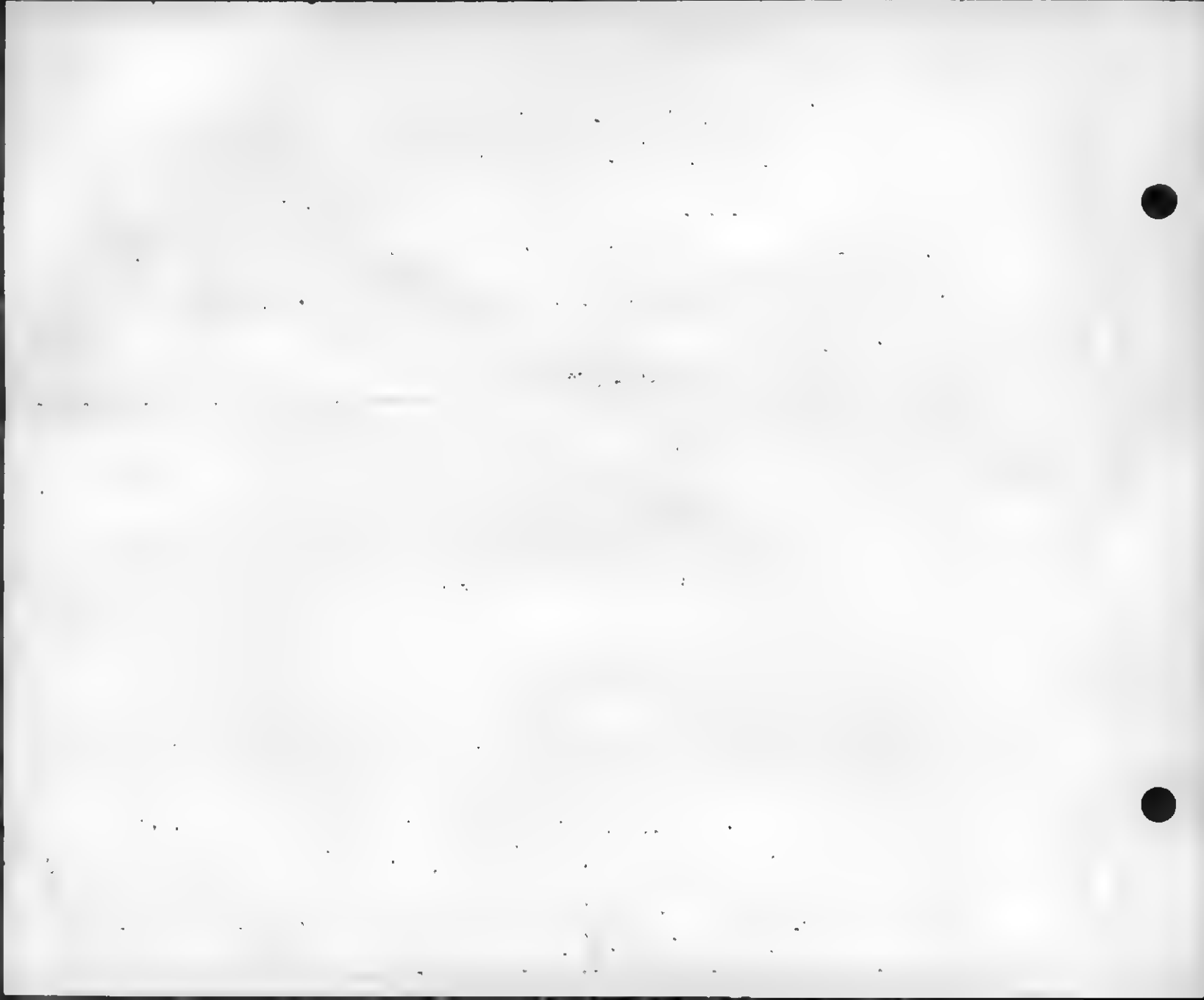


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) HELEN ELIZABETH GREENE			2a. DATE OF DEATH Month 3 Day 7 Year 68			2b. HOUR 7:30 AM	
3. SEX FEMALE		4. RACE CAUCAS. AN.		5. DATE OF BIRTH 1-19-97		6. AGE (In years lost birthday) 71 YRS.	
7a. BIRTHPLACE (State or foreign country) PA.		7b. CIT-ZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own home	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INS DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 8306 16th Street		14. FATHER'S NAME First Edward Middle Eckman Last Boyle		15. MOTHER'S MAIDEN NAME First Catherine Middle Boyle Last Boyle			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 216-14-1658		17. INFORMANT John H. Greene		Address 8306 16th St., Sil. Spr., Md.	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))							
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute coronary thrombosis with myocardial infarction							
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary atherosclerosis							
DUE TO, OR AS A CONSEQUENCE OF (c) Several years							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus; cerebral thromboses							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from February 25, 1968 , to March 7, 1968 , that (I) (we) last saw the deceased alive on March 6, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Bennet A. Porter, Jr., M.D.		22c. DATE SIGNED March 7, 1968		22d. PHYSICIAN'S NAME (Type) Bennet A. Porter, Jr., M.D.		22e. ADDRESS 9301 Coleville Rd., Silver Spring, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Mar. 9, 1968		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven cemetery		23d. LOCATION (City or Town) (County) (State) Silver Spring Montg. Maryland	
24. FUNERAL DIRECTOR Clark E. Wison		24a. ADDRESS Warner E. Pumphrey Inc., 8434 Ga., Ave., S.S.		25a. RECD BY REGISTRAR MAR 8 1968		25b. REGISTRAR'S SIGNATURE [Signature]	

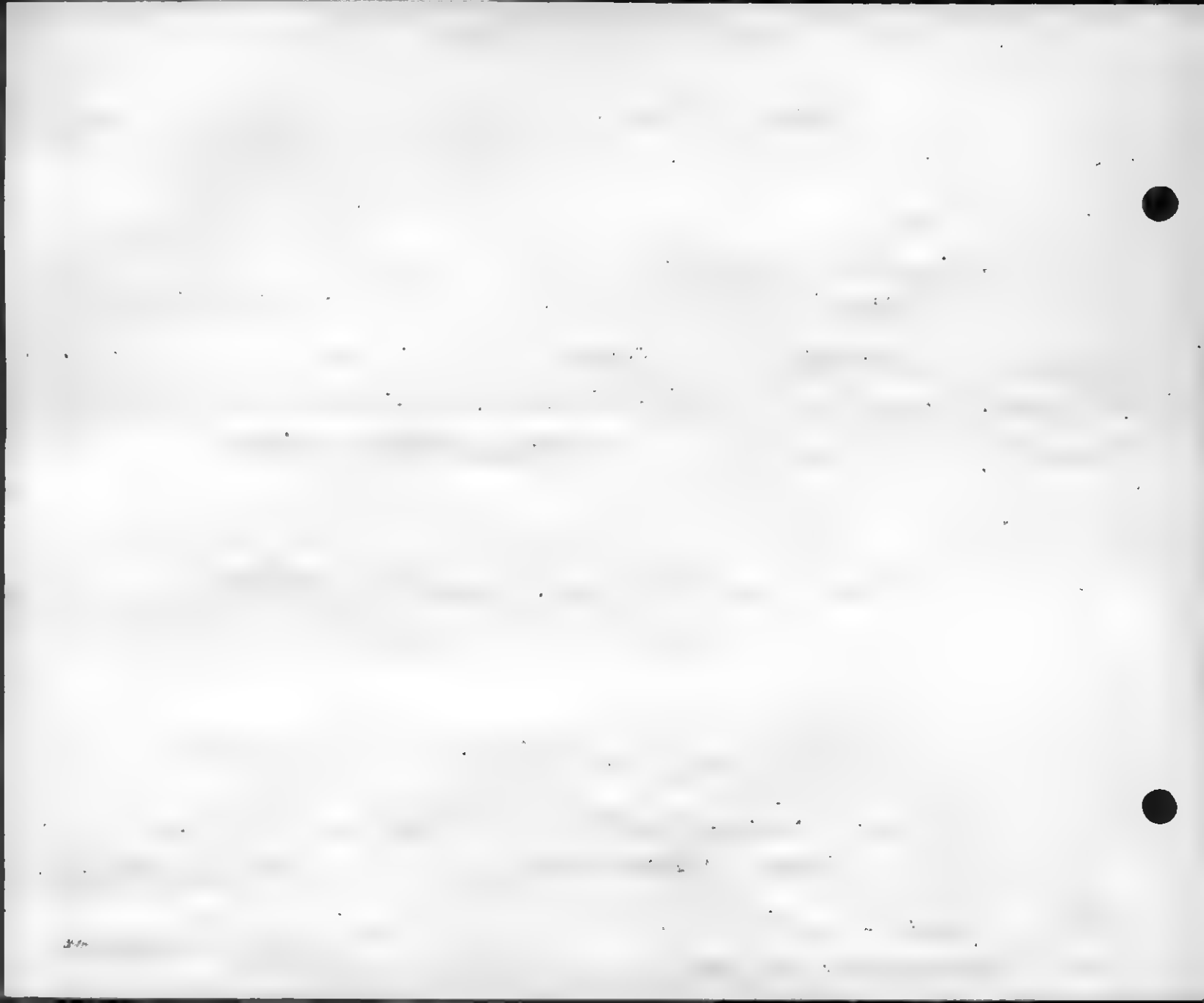


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <i>Sadie Edith Greif</i>			2a. DATE OF DEATH Month <i>3</i> Day <i>26</i> Year <i>1968</i>			2b. HOUR <i>4:48 PM</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>11-22-1900</i>		6. AGE (In years last birthday) <i>67</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Russia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>Amer.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Wash. San. & Hosp.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>House</i>		12b. KIND OF BUSINESS OR INDUSTRY —	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Montgomery</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>8453 12th Ave.</i>	
14. FATHER'S NAME First Middle Last <i>Morris Serkin</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Miriam Charnin</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>		16b. SOCIAL SECURITY NO. <i>217-52-9877</i>		17. INFORMANT <i>Hosp. Record</i>		Address <i>7600 Carroll An.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> <i>410.9</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4 Bronchial Asthma, Diabetes Mellitus</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb 29, 1968</i> to <i>March 26, 1968</i> , that (I) (we) last saw the deceased alive on <i>March 26, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Boris Rabin, MD</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <i>3-26-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>BORIS RABKIN, MD</i>		22e. ADDRESS <i>1019 Univ. Blvd. E. Silver Spring, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMIAL</i>		23b. DATE <i>3/28/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>ARLINGTON B.M.</i>		23d. LOCATION (City or Town) (County) (State) <i>ARL. VA.</i>	
24. FUNERAL DIRECTOR <i>Leah Ferguson</i>		ADDRESS <i>4217-9-2nd</i>		25a. REC'D BY REGISTRAR <i>DATE</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Judge</i>	



FOR STATE HEALTH DEPT.

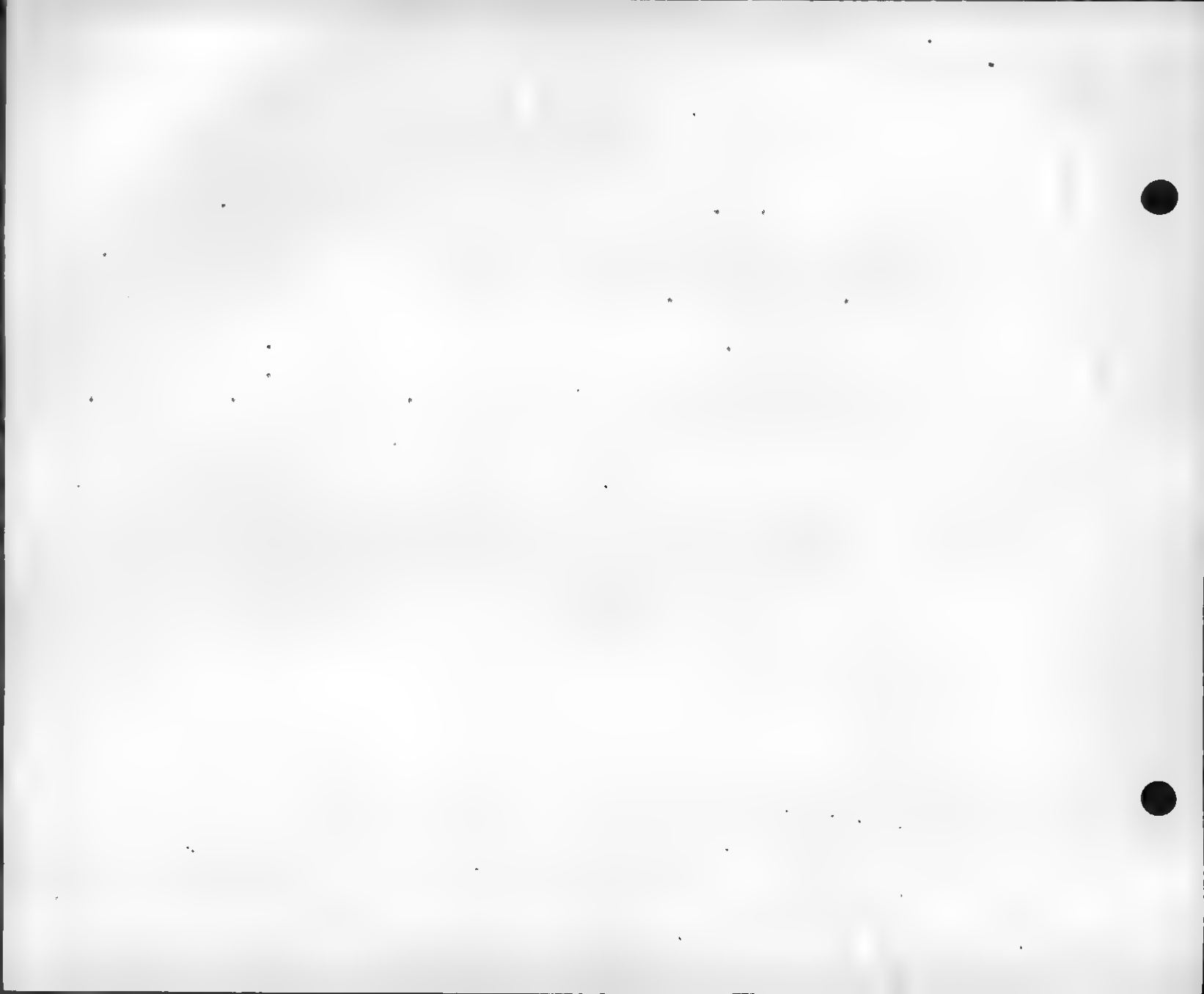
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) ROSS A. GRIDLEY			2a DATE KNOWN OF DEATH Month 03 Day 03 Year 1968			2b HOUR 2:45 PM			
3 SEX Male	4 RACE White	5 DATE OF BIRTH 12/5/92	6 AGE (In years last birthday) 75 YRS	7 UNDER 1 YEAR MONTHS DAYS	8 UNDER 24 HRS HOURS MIN.	2c DATE PRONOUNCED DEAD Month 03 Day 03 Year 1968			
7a BIRTHPLACE (State or foreign country) Kansas		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md			
10. CITY OR TOWN OF DEATH Olney		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Civil Engineer		12b KIND OF BUSINESS OR INDUSTRY Eng.		
13a U.S.A. RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md.			13b COUNTY Montg.		13c CITY OR TOWN Silver Spring		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
13e STREET AND NUMBER 3386 Chiswick Ct.									
14 FATHER'S NAME First Hugh Middle B. Last Gridley			15. MOTHER'S MAIDEN NAME First Nellie Middle T. Last Edgerton						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) yes			16b SOCIAL SECURITY NO 1918-1919 579-48-0610		17. INFORMATION Medical Records Dept. of Montg. General Hosp., Olney, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) Coronary Artery Heart Disease. DUE TO OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State					
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Belden K. Reap		EXAMINER'S NAME (Type) BELDEN K. REAP M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/3/1968			
23a BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b DATE 3/4/68		23c NAME OF CEMETERY OR CREMATORY Cedar Hill		23d LOCATION (City or Town) (County) (State) Prince George Md.			
24. FUNERAL DIRECTOR Lyson Wheeler Funeral Home				ADDRESS 1551 Rock Pike Rockville, Md.		25a RECD BY REGISTRAR DATE MAR 5 1968		25b REGISTRAR'S SIGNATURE Charles J. J...	



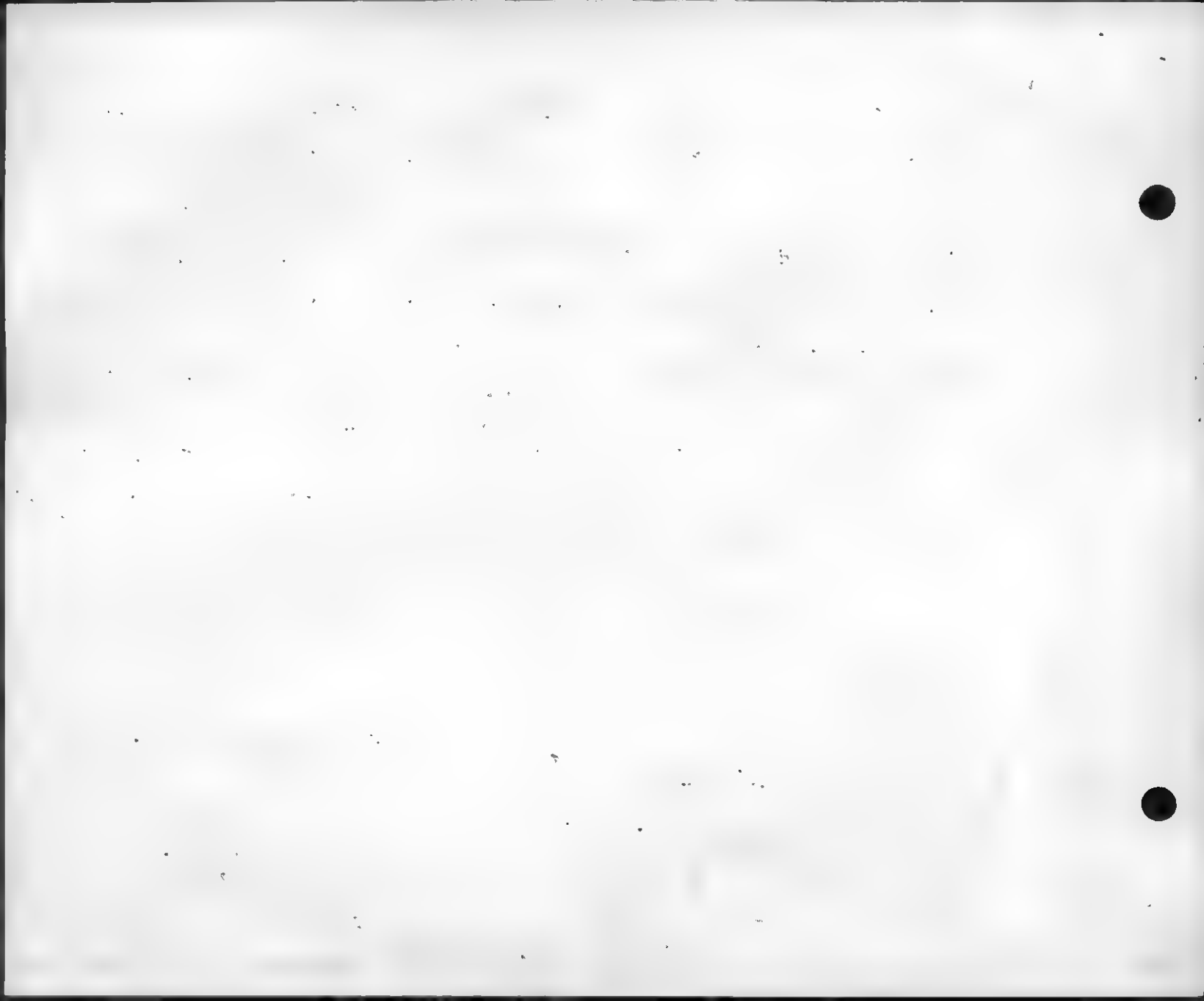
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR ATS (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) MINNIE A GRISSINGER			2a DATE OF DEATH Month MARCH Day 22 Year 1968		2b. HOUR 8:45 AM
3. SEX Female	4 RACE White	5. DATE OF BIRTH JAN. 20 - 1881		6 AGE (In years lost birthday) 87 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) PENNA.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY Md.		
10. CITY OR TOWN OF DEATH KENSINGTON		11 NAME OF HOSPITAL OR INSTITUTION (if not a hospital give street address) CARROLL HALL 10231 CARROLL PK. SAN		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Post-mistress-Ret.	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland COUNTY Montgomery CITY OR TOWN Caithersburg		13b INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13c STREET AND NUMBER 19117 N. Kindly Court		
14. FATHER'S NAME First Middle Last Charles Tisch		15. MOTHER'S MAIDEN NAME First Middle Last Laura Atherton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b SOCIAL SECURITY NO.		17 INFORMANT Daughter Address Same as Item 13. Mrs. de la Montaigne	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral arterial thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 5 years?					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (the hospital) attended the deceased from 1965 , to MAR. 22, 1968 , that (I) (we) lost saw the deceased alive on MAR. 22, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.					
22b. SIGNATURE Morris Perry DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c DATE SIGNED MAR. 22, 1968	
22d. PHYSICIAN'S NAME (Type) Morris Perry		22e. ADDRESS 11602 Georgia Ave. Silver Spring, Maryland			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-26-68		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery	
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		23d. LOCATION (City or Town) (County) (State) Selinsgrove, Penna.		25a. REC'D BY REGISTRAR MAR 26 1968	
				25b. REGISTRAR'S SIGNATURE	

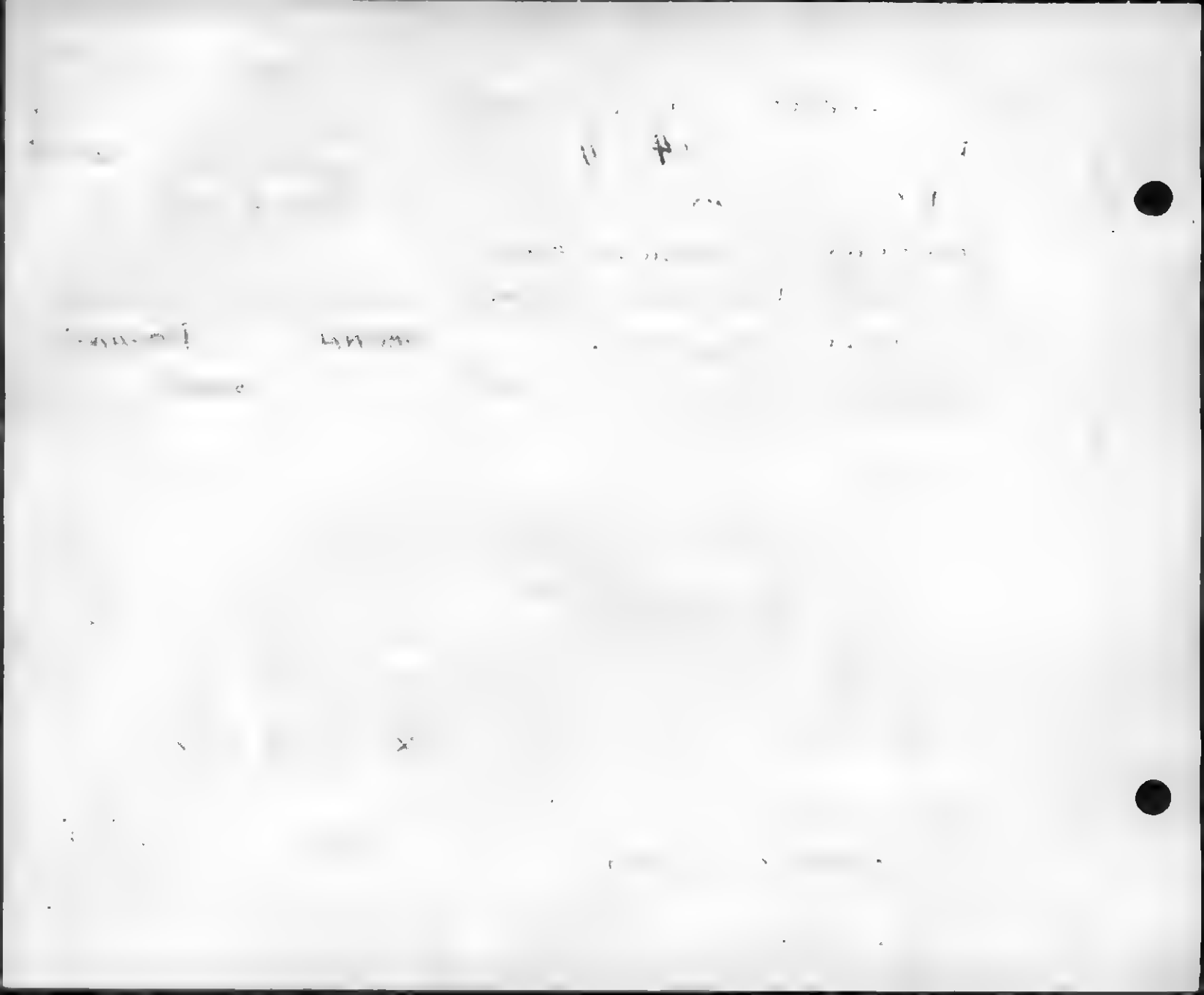


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print) DARLENE ANN GUNNOE						2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 3 18 1968			2b. HOUR 12 1/2 PM		
3. SEX F	4. RACE W	5. DATE OF BIRTH 2-27-64	6. AGE (in years last birthday) 4 YRS	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month 3 Day 18 Year 1968			2d. HOUR 12 1/2 PM		
7a. BIRTHPLACE (State or foreign country) D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md					
10. CITY OR TOWN OF DEATH TAKOMA PARK			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASH SAN & HOSP			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD COUNTY PRINCE GEORGE			13c. CITY OR TOWN HYATTSVILLE		3a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13b. STREET AND NUMBER 5425 16TH AVE.				
14. FATHER'S NAME First BILLY Middle LEE Last GUNNOE				15. MOTHER'S MAIDEN NAME First LEONA Middle DOLAN Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16b. SOCIAL SECURITY NO		17. INFORMANT LEONA KRAMER ADDRESS MOTHER - 5520 Downgate Ct. Rockville, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute generalized peritonitis secondary DUE TO, OR AS A CONSEQUENCE OF to perforation of jejunum, cause unknown Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 19 HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK HOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Belden R. Reap		EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/18/1968	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE March 20, 1968		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery				23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.			
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.				25a. REC'D BY REGISTRAR MAR 21 1968		25b. REGISTRAR'S SIGNATURE James J. Jones	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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4336
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) RICHARD		First HENRY		Middle GUNTHER		Last GUNTHER		2a. DATE OF DEATH 3 Month 15 Day 1968 Year			2b. HOUR M. 10:36	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 6-24-12			6. AGE (In years last birthday) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.						
10. CITY OR TOWN OF DEATH U. NEY		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MONTGOMERY GENERAL HOSPITAL				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) DISABLED			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY HOWARD		13c. CITY OR TOWN GLENEIG		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER TRIDELPHIA ROAD				
14. FATHER'S NAME First Middle Last HENRY GUNTHER				15. MOTHER'S MAIDEN NAME First Middle Last MARY K. BUTKE								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 215-03-4325		17. INFORMANT MEDICAL RECORDS				Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) COR PULMONALE - C.H.F. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Days												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) BRONCHOPNEUMONIA, BILAT. 3 WKS												
(c) PULMONARY EMPHYSEMA 10 YRS												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CEREBRAL EDEMA - RECENT												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from DEC 1964 to 15 MAR 1968 , that (I) (we) last saw the deceased alive on 15 MAR 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Ronald R. Lewis M.D.		22c. DATE SIGNED 16 MAR 68		22d. PHYSICIAN'S NAME (Type) DONALD R. LEWIS, M.D.		22e. ADDRESS 700 CLOVERLY STREET, SILVER SPRING, M.D.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3-18-68		23c. NAME OF CEMETERY OR CREMATORY CREST LAWN		23d. LOCATION (City or Town) ELlicott City		(County) Howard		(State) md		
24. FUNERAL DIRECTOR Hightsham - Slack		ADDRESS Ellicott City md.		25a. REC'D BY REG STRAR DATE MAR 21 1968		25b. REGISTRAR'S SIGNATURE J. Charles Jones						

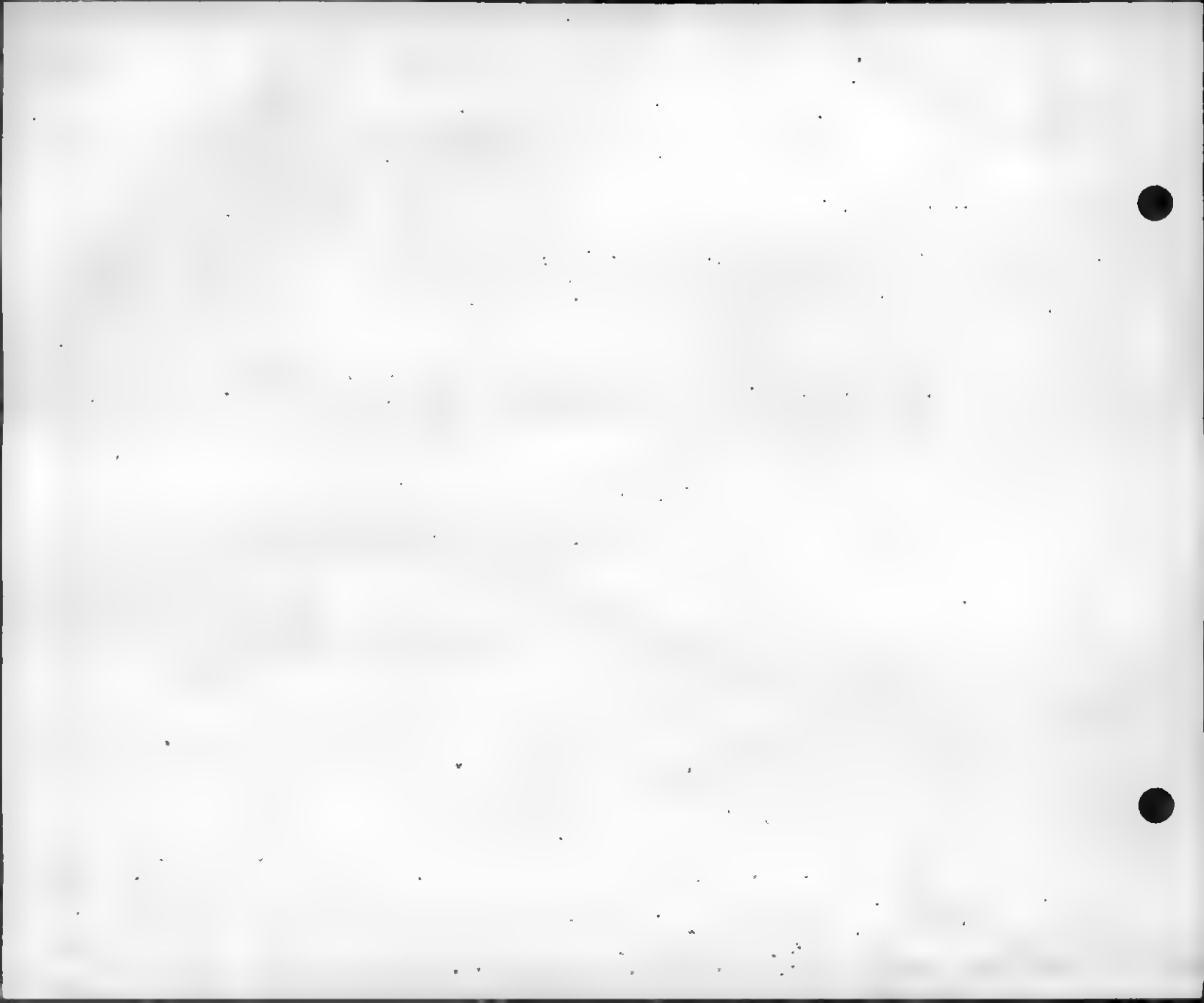


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last Russell Vernon Hager			2a. DATE OF DEATH Month Day Year March 12, 1968		2b. HOUR AM PM 12:55 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH June 21, 1920		6. AGE (In years last birthday) 47 YRS	IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) District of Columbia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Montgomery Md.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Supervisory Accountant		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12b. KIND OF BUSINESS OR INDUSTRY Fed. Gov't	
13a. USUAL RESIDENCE (Where deceased lived, institution, residence before admission), STATE Virginia		13b. COUNTY --	13c. CITY OR TOWN Alexandria	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 5430 Brookland Road
14. FATHER'S NAME First Middle Last Leon Hager			15. MOTHER'S MAIDEN NAME First Middle Last Vera Stansbury		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) Yes 1942-1945		16b. SOCIAL SECURITY NO. Not available		17. INFORMANT The Medical Records address The Clinical Center, Bethesda, Md. 20014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO, OR AS A CONSEQUENCE OF (b) Bilateral Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Myelogenous Leukemia					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 3 days 3 years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 2041					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (it) (this hospital) attended the deceased from January 18, 1968 , to March 12, 1968 , that (it) (we) last saw the deceased alive on March 12, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (it) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert A. Ralph MD DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22c. DATE SIGNED 12 March 1968	
22d. PHYSICIAN'S NAME (Type) Robert A. Ralph, M.D.				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE 3/15/68		23c. NAME OF CEMETERY OR CREMATORY Mount Comfort Cemetery	
23d. LOCATION (City or Town) (County) (State) Fairfax County, Virginia		23e. REC'D BY REGISTRAR Charles J. J...			
24. FUNERAL DIRECTOR The Derrine Funeral Homes, Inc., Alexandria, Va.		25a. DATE MAR 18 1968			

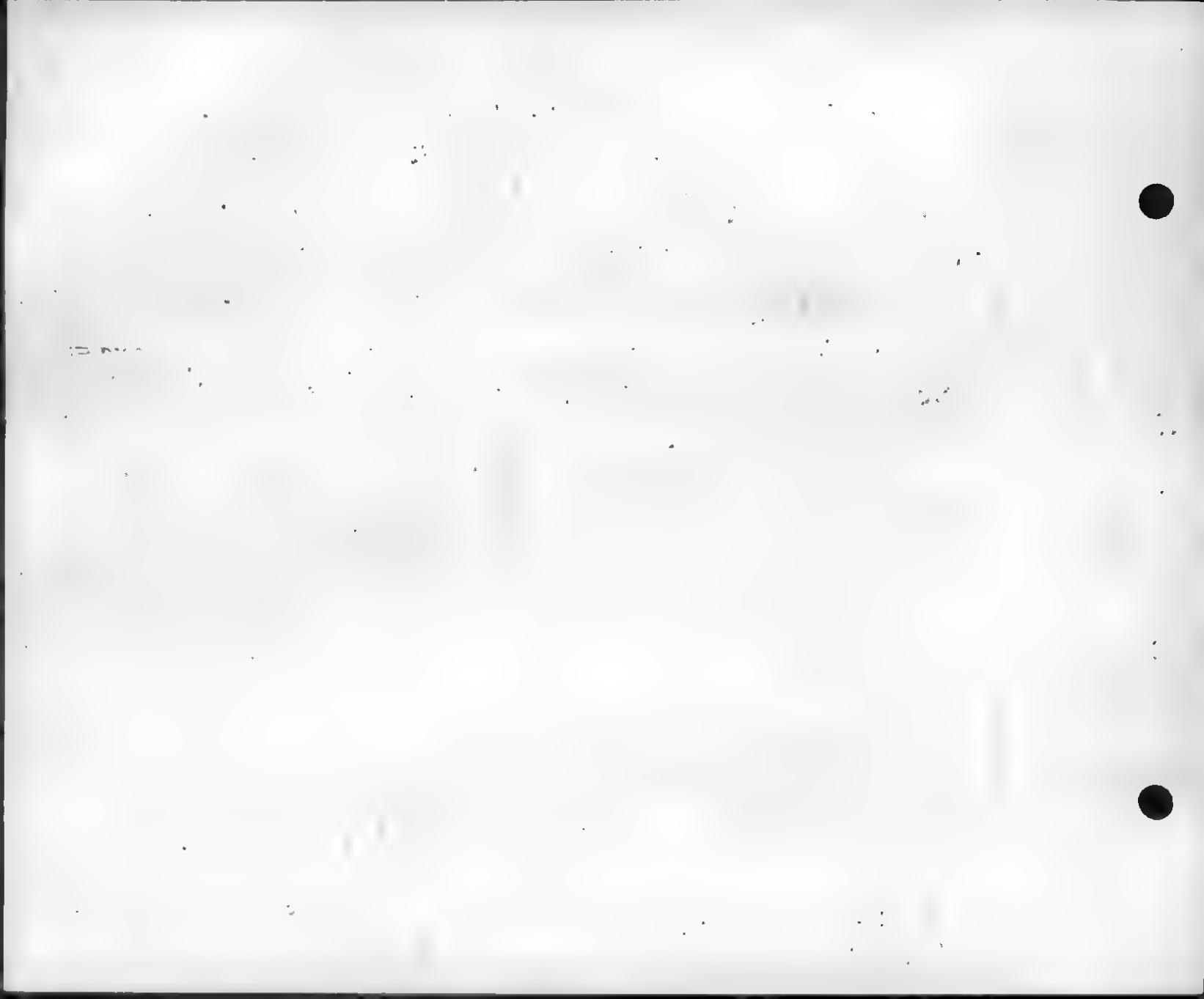


Cleared with Dr. Reap.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
DECEASED NAME (Type or print) First Middle Last RITA W. HAGGERTY						2a. DATE OF DEATH Month Day Year 3 20 68		2b. HOUR 9:45 A M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 5-28-16		6. AGE (In years last birthday) 51 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS M.N.		IF UNDER 24 HRS	
7a. BIRTHPLACE (State or foreign country) MASS.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md					
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASH. SAN + HOSP.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY At home			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND		13b. COUNTY HYATTSVILLE		13c. CITY OR TOWN HYATTSVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5107 EDMONSTON AVE.			
14. FATHER'S NAME First Middle Last MICHAEL COYNE				15. MOTHER'S MAIDEN NAME First Middle Last CATHERINE SHIELDS JOYCE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 012-636909		17. INFORMANT LAWRENCE C. HAGGERTY		Address Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver coma										6 hours	
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Malignancy advanced										4 years	
DUE TO, OR AS A CONSEQUENCE OF (c) Cancer of Right Breast										8 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cancer of Rt Breast with metastases since 1-4-62 - under my care until her death.											
19a. DATE OF OPERATION 1-5-67		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer - metastatic from Breast		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 1-4 , 19 62 , to 3-20 , 19 68 , that (I) (we) last saw the deceased alive on Feb 23 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE James H. Scully M.D.						22c. DATE SIGNED 3-20-68					
22d. PHYSICIAN'S NAME (Type) James H. Scully						22e. ADDRESS 1835 E St N.W. Wash 20006					
23a. BURIAL, CREMATION, REMOVA, (Specify) BURIAL		23b. DATE 23 MAR 1968		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION (City or Town) (County) (State) WHEATON, MARYLAND					
24. FUNERAL DIRECTOR W.W. CHAMBERS Co RIVERDALE, MD						25a. REC'D BY REGISTRAR MAR 26 1968		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) ROLAND N. HAINES		2a DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month MARCH Day 2 Year 1968		2b HOUR 4:45 M
3 SEX MALE	4 RACE W	5 DATE OF BIRTH 7-26-05	6 AGE (in years last birthday) 62 YRS	7c MONTHS 1
7a BIRTHPLACE (State or foreign country) Petersville PA		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10 CITY OR TOWN OF DEATH BETHESDA		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Suburban		12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) U.S. Post Office
13a U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b COUNTY Montgomery		13c CITY OR TOWN BETHESDA
14 FATHER'S NAME Thomas L Haines		15 MOTHER'S MAIDEN NAME Estelle New Town		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 1943-1944
16b SOCIAL SECURITY NO. 1943-1944		17 INFORMANT (Wife) Mildred L. Haines		18 ADDRESS 4400 East West Highway
19 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency Acute. DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Occlusion + Sclerosis - DUE TO, OR AS A CONSEQUENCE OF (c) Cardio Vascular Disease -				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE John G. Ball		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED March 2, 1968
EXAMINER'S NAME (Type) JOHN G. BALL		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) Bethesda, Md.
23a BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b DATE March 3/68		23c NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY,		ADDRESS BETHESDA, MARYLAND		25a REC'D BY REGISTRAR MAR 8 1968
				25b REGISTRAR'S SIGNATURE [Signature]



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

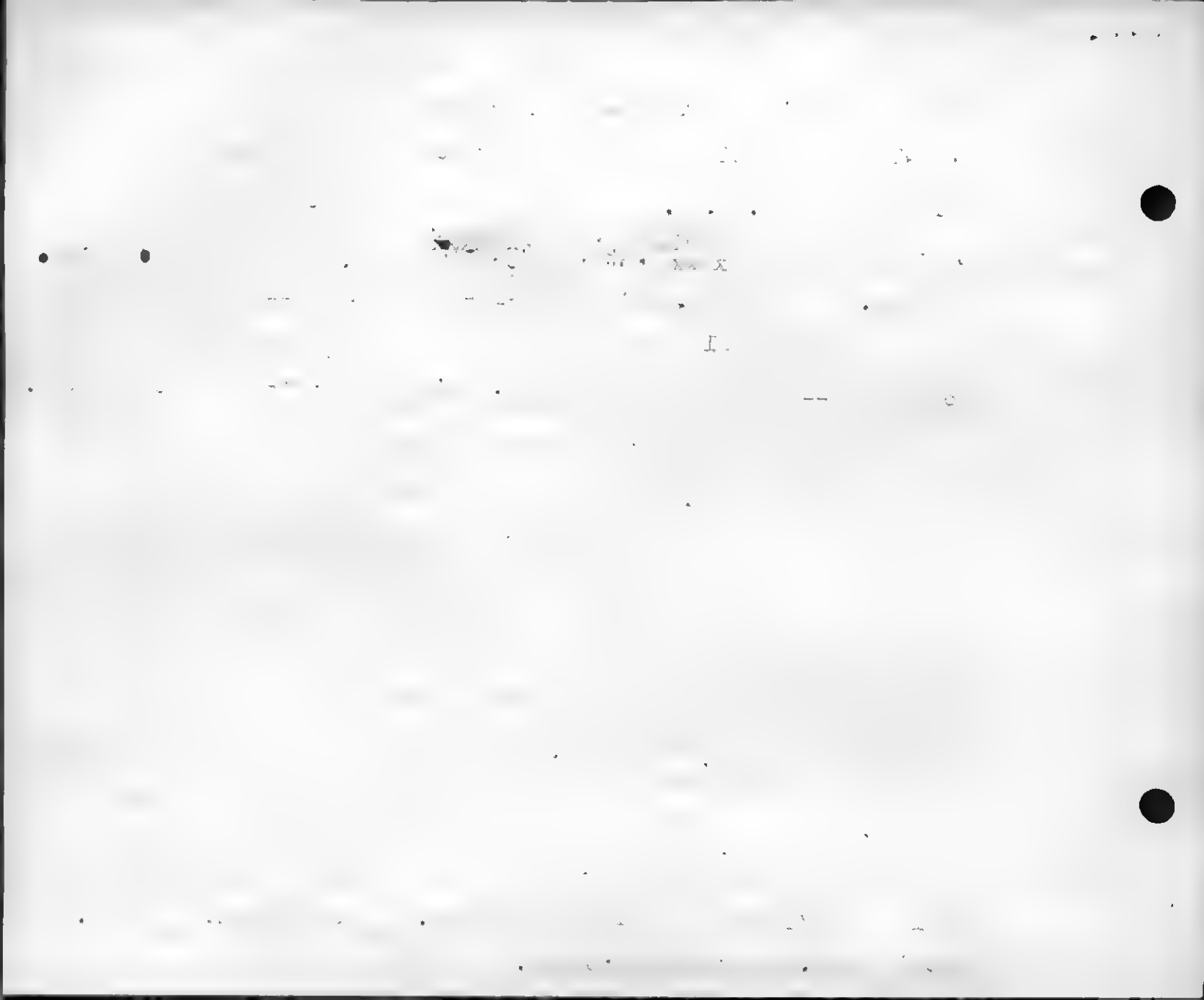
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print) <i>Boy</i>			First Middle Last <i>Hamilton</i>			2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <i>1968</i>		2b. HOUR <i>2:30</i> AM	
3 SEX <i>Male</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>3/21/68</i>	6 AGE (In years last birthday) <i>5B</i>	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PROMOTED DEAD Month <i>March</i> Day <i>21</i> Year <i>1968</i>		2d. HOUR <i>2:30</i> AM	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Infant</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution residence before admission) STATE <i>Md</i>			13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Kosciusko</i>	3d. INSIDE CITY, IN 15? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>4412 Jupiter St</i>		
14 FATHER'S NAME First Middle Last <i>Kenneth Ray Carter</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Mary Anne Hamilton</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)			16b. SOCIAL SECURITY NO.		17 INFORMANT <i>Matthew</i>		ADDRESS <i>Home</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congenital Atelectasis -</i> <i>776.9</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Immaturity - 830 gms. -</i> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John S. Bell</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>3/25/68</i>			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
			ADDRESS (Street, city, town, or county)						
23a. BURIAL (CREMATION) REMOVAL (Specify)		23b. DATE <i>3/25/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Suburban Hospital</i>		23d. LOCATION (City or Town) (County) (State) <i>Bethesda - Montgomery - Md.</i>			
24. FUNERAL DIRECTOR <i>Mrs. Annie C. Catey, Administrator</i>			ADDRESS <i>" "</i>			25a. REC'D BY REGISTRAR <i>DATE 27 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH													
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR				
Sarah Theresa Hardisty						Month Day Year			40 M				
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years lost birthday)		7 UNDER 1 YEAR		7 UNDER 24 HRS		
Female		White		May 30, 1875			92 YRS.		MONTHS DAYS		HOURS MIN		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8-MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Illinois			U. S. A.						Montgomery County,			Md	
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not at home)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY				
Bethesda			Spring Bethesda - Office			Housewife			Own Home				
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?			13e STREET AND NUMBER	
Md.			Pr. Geo's			Vine Mitchell-			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			--	
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
John McGrail			Mary Robinson										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b SOCIAL SECURITY NO			17 INFORMANT			Address				
No						Mrs. Emily Schubert-Mitchellville, Md.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Ischemic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CORONARY ARTERIOSCLEROSIS</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>6 years</u> <u>6 years</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Carcinoid Tumor - Cerebral Arteriosclerosis - Chronic Brain Syndrome</u>													
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
			HOUR A.M. Month Day Year P.M. 19										
21d INJURY OCCURRED <input type="checkbox"/> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>46</u> , to <u>March 9</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>March 5</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE								22c DATE SIGNED					
<u>Andrew G. Prandoni MD</u>								3/9/68					
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS							
<u>Andrew G. Prandoni</u>						<u>2520 L St. NW Washington DC</u>							
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)				
<u>Burial</u>			<u>3/12/68</u>			<u>Holy Trinity Cem.</u>			<u>Collington, Md.</u>				
24 FUNERAL DIRECTOR						25a RECD BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
<u>Ritchie Bros. Upper Marlboro, Md.</u>						<u>MAR 14 1968</u>			<u>J. Charles Judge</u>				

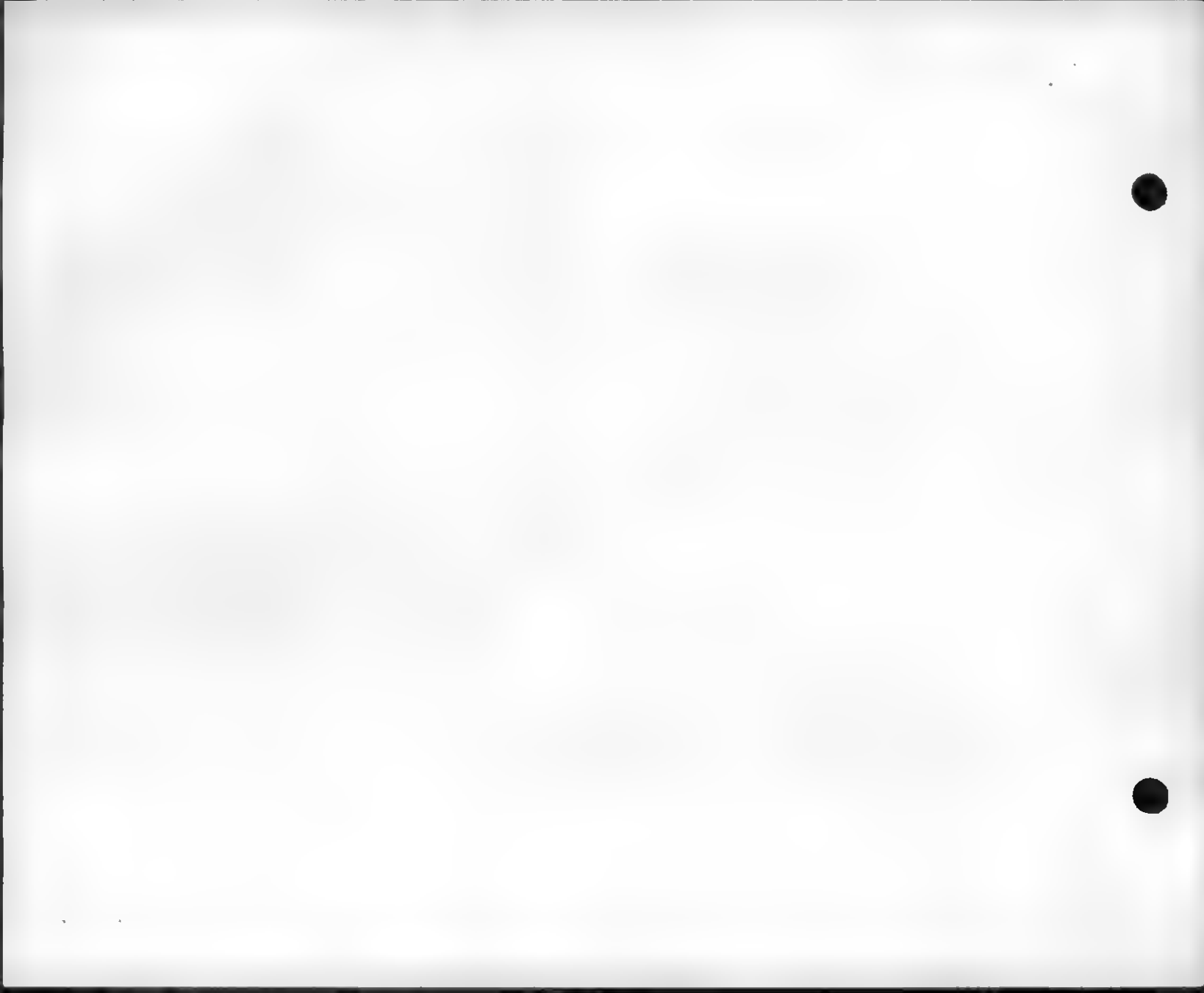


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Robert L. Harrison			2a. DATE OF DEATH Month March Day 21 Year 1968			2b. HOUR 12:24 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 5-14-86		6. AGE (In years last birthday) 81 YRS.	
7a. BIRTHPLACE (State or foreign country) Quebec, Canada		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban		12a. USUAL OCCUPATION (Kind of work done during last working life, even if retired) Retired engineer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 10712 Rockville St.		14. FATHER'S NAME First William Middle Crawford Last Harrison		15. MOTHER'S MAIDEN NAME First Freda Middle Feuchter Last Feuchter		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO.		17. INFORMANT Wife, Kettie Harrison		Address Same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Carcinoma, Rt. Lung DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48h 3wd							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1624							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1960 , 19 3-10 , to 3-20 , 19 68 , that (I) (we) last saw the deceased alive on 3-20 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Sarah E. Glover M.D. DEGREE M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						22c. DATE SIGNED 3-21-68	
22d. PHYSICIAN'S NAME (Type) Sarah E. Glover, M.D.		22e. ADDRESS 10128 CEDAR LANE Kensington Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 3/23/68		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Montgomery County, Md.	
24. FUNERAL DIRECTOR S.H. Hines Co., Wash. D.C. ADDRESS				25a. REC'D BY REGISTRAR MAR 26 1968		25b. REGISTRAR'S SIGNATURE Charles J. Jones	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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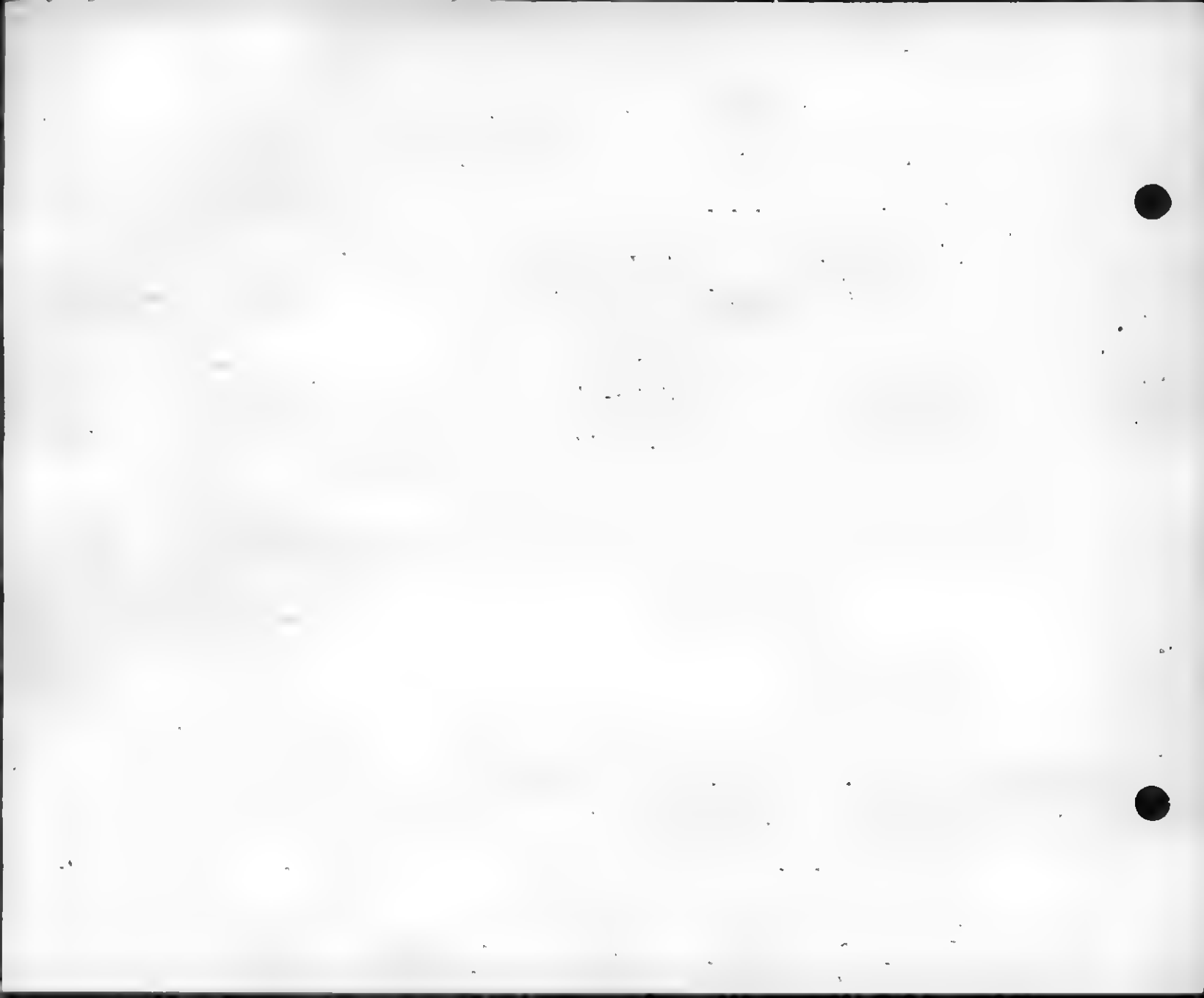
Approved by coroner Dr. Beldin Leap

MD343

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) William Nathaniel Hassell			2a. DATE OF DEATH Month 3 Day 2 Year 68			2b. HOUR 6:35 AM	
3. SEX MALE		4. RACE CAUC.		5. DATE OF BIRTH Sept. 7, 1901		6. AGE (In years last birthday) 66 YRS	
7a. BIRTHPLACE (State or foreign country) Md. Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Engineer		12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE MD. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2301 Darrow St	
14. FATHER'S NAME First William Middle Hassell Last Hassell			15. MOTHER'S MARDEN NAME First Julia Middle Gamble Last Gamble				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 060-10-4516		17. INFORMANT 2301 Darrow Street Carrice S. Hassell Silver Spring, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral hemorrhage 4:51 PM DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 hrs							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 351.5							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Jan 1967 to 3-2-68 , that (I) (we) last saw the deceased alive on 3-1-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE G. L. Jengstack M.D.				22c. DATE SIGNED 3-2-68			
22d. PHYSICIAN'S NAME (Type) G. L. Jengstack				22e. ADDRESS 9241 Columbia Blvd. Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 5, 1968		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City or Town) (County) (State) Silver Spring, Maryland	
24. FUNERAL DIRECTOR C. Glen Carter Warner E. Pumphrey, Inc.		434 Georgia Ave. Silver Spring, Md.		25a. REC'D BY REGISTRAR MARK		25b. REGISTRAR'S SIGNATURE 8 1968	



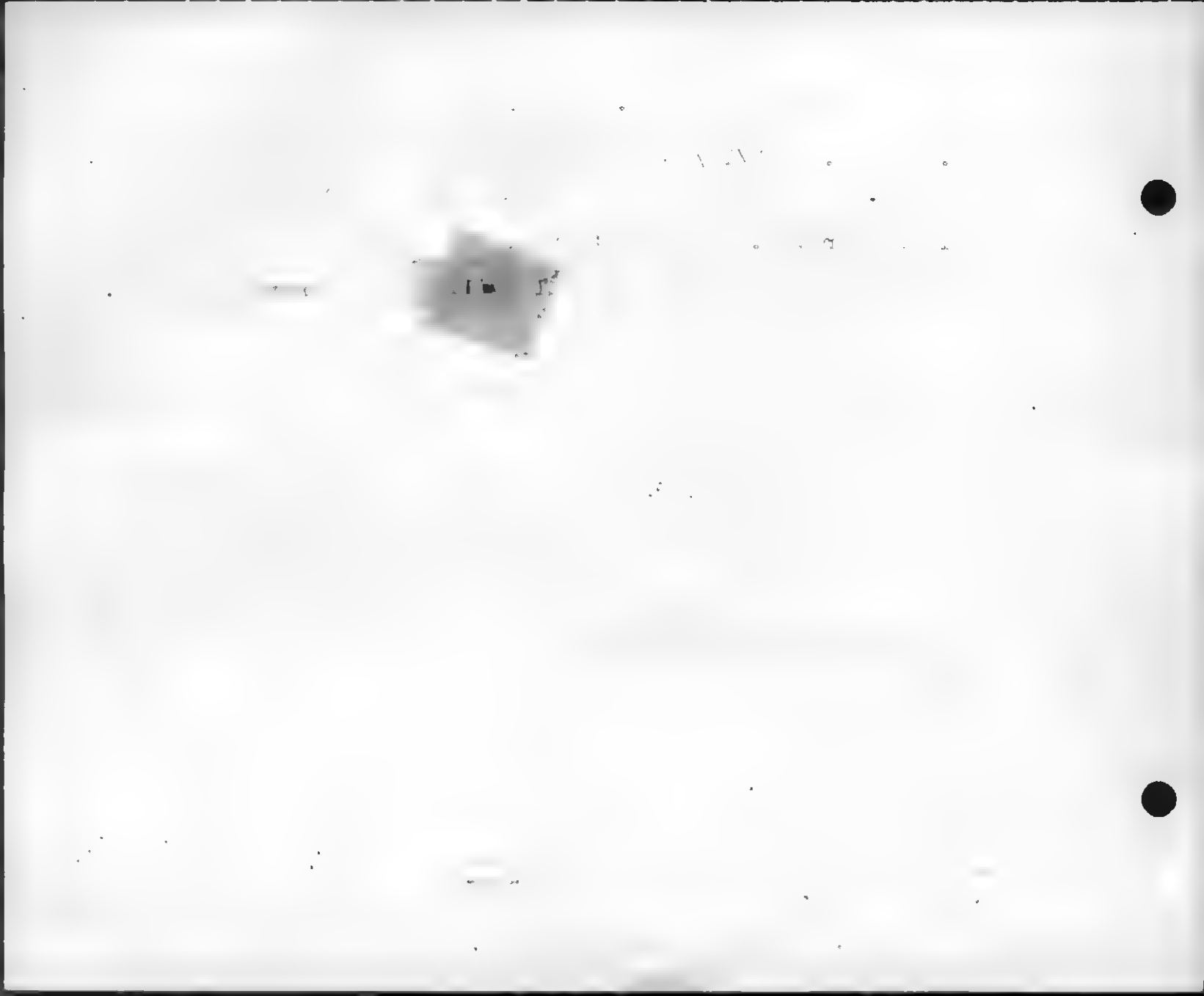
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) ARTHUR J. HASSETT		2a DATE KNOWN OF DEATH Month 03 Day 19 Year 1968		2b HOUR 8:05 PM
3 SEX M.	4 RACE Wh.	5 DATE OF BIRTH 02/19/88	6 AGE (in years last birthday) 80 YRS	7c DATE PRONOUNCED DEAD Month 03 Day 19 Year 1968
7a BIRTHPLACE (State or foreign country) Mass.		7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH Silver Spring, Md.		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Holy Cross		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired registrar
13a USUAL RESIDENCE (Where deceased lived if institution residence before admission) STATE Mass.		13b COUNTY Plymouth		13c CITY OR TOWN Brockton
14 FATHER'S NAME John S Hassett		15 MOTHER'S MAIDEN NAME Margaret Riordan		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b SOCIAL SECURITY NO (If yes give war or dates of service)		17 INFORMANT /John P Hassett
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201				
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion				
ACTUAL SIGNATURE Belden R. Reap		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED 3/19/1968
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE March 23, 1968	23c NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.		25a. RECEIVED BY REGISTRAR MAR 21 1968
		25b. REGISTRAR'S SIGNATURE [Signature]		



CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <u>Albert Burdette Hawse</u>			2a. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>1968</u>			2b. HOUR <u>2:19 AM</u>	
3 SEX <u>Male</u>		4 RACE <u>White</u>		5. DATE OF BIRTH <u>9 - 29 - 1903</u>		6 AGE (In years last birthday) <u>64</u> YRS.	
7a. BIRTHPLACE (State or foreign country) <u>Ind. (Mond)</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md.	
10 CITY OR TOWN OF DEATH <u>Bethesda</u>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Well Driller</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>W.B. Hilton</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Boyd's</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <u>Box 218</u>		13f. ROUTE <u>Route 1</u>		14 FATHER'S NAME First Middle Last <u>James C Hawse</u>		15 MOTHER'S MAIDEN NAME First Middle Last <u>Hertrude E. Burdette</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <u>No</u>		16b. SOCIAL SECURITY NO. <u>216-22-0419</u>		17 INFORMANT <u>Wife Alice Hawse - Same as Above</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Ca. (Lung) with gen. metastases</u> <u>1621</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>1621</u>							
19a. DATE OF OPERATION <u>2-23-68</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Tumor (Lung)</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 22, 1968</u> , to <u>March 1, 1968</u> , that (I) (we) last saw the deceased alive on <u>March 1, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>V.C. de Guzman MD</u>						22c. DATE SIGNED <u>March 1, 1968</u>	
22d. PHYSICIAN'S NAME (Type) <u>V.C. de Guzman</u>						22e. ADDRESS <u>1234 19 NW WASH DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>3/4/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		23d. LOCATION (City or Town) (County) (State) <u>Barnesville Md. Ind.</u>	
24 FUNERAL DIRECTOR <u>William C. Hill - Barnesville Md.</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 7 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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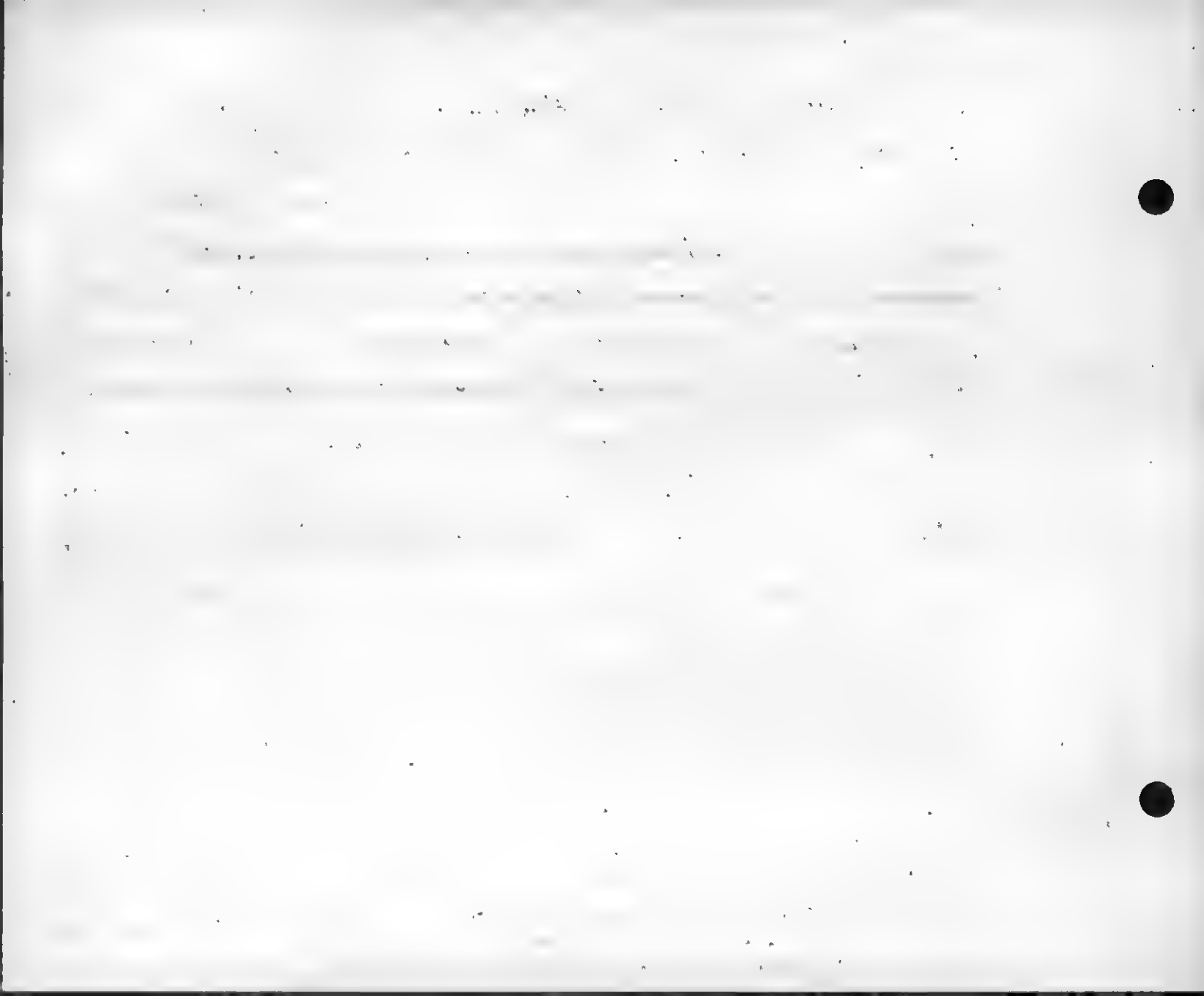
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1346

1483

1. DECEASED NAME (Type or print) DAISY			First S Middle HAYCRAFT Last			2a. DATE OF DEATH Month 3 Day 15 Year 68			2b. HOUR 1035 PM		
3. SEX FEMALE			4. RACE EAUC.			5. DATE OF BIRTH March 16, 1871			6. AGE (In years or birthday) 96 YRS		
7a. BIRTHPLACE (State or foreign country) MINN.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH MONTGOMERY Md.		
10. CITY OR TOWN OF DEATH SILVER SPRING			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) FAIRLAND NURSING HOME			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) REAL ESTATE BROKER			12b. KIND OF BUSINESS OR INDUSTRY		
13a. U.S. RESIDENCE (Where deceased lived, if institution Residence before admiss on) STATE MARYLAND			13b. COUNTY MONTGOMERY			13c. CITY OR TOWN KENSINGTON			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 3927 Washington Street			14. FATHER'S NAME First CHARLES Middle SYLVESTER Last			15. MOTHER'S MAIDEN NAME First CHARLOTTE Middle BUCKS Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 578-48-5897			17. INFORMANT INFORMATION TAKEN FROM CHART			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebro-vascular accident DUE TO, OR AS A CONSEQUENCE OF (c) Chronic nephritis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days		
									12 days		
									10-15 years		
									PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan. 27, 1960 , to March 15, 1968 , that (I) (we) last saw the deceased alive on March 15, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Katharine A. Chapman, M.D. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED March 15, 1968					
22d. PHYSICIAN'S NAME (Type) Katharine A. Chapman						22e. ADDRESS 3924 Baltimore St. Kensington, Md. 20795					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 3/19/68			23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery			23d. LOCATION (City or Town) (County) (State) Washington D. C.		
24. FUNERAL DIRECTOR Robert E. Wilhelm ADDRESS Federal Home 4308 Suitland Road, Suitland, Maryland						25a. REC'D BY REGISTRAR DATE MAR 21 1968			25b. REGISTRAR'S SIGNATURE Judge		

MEDICAL CERTIFICATION



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68



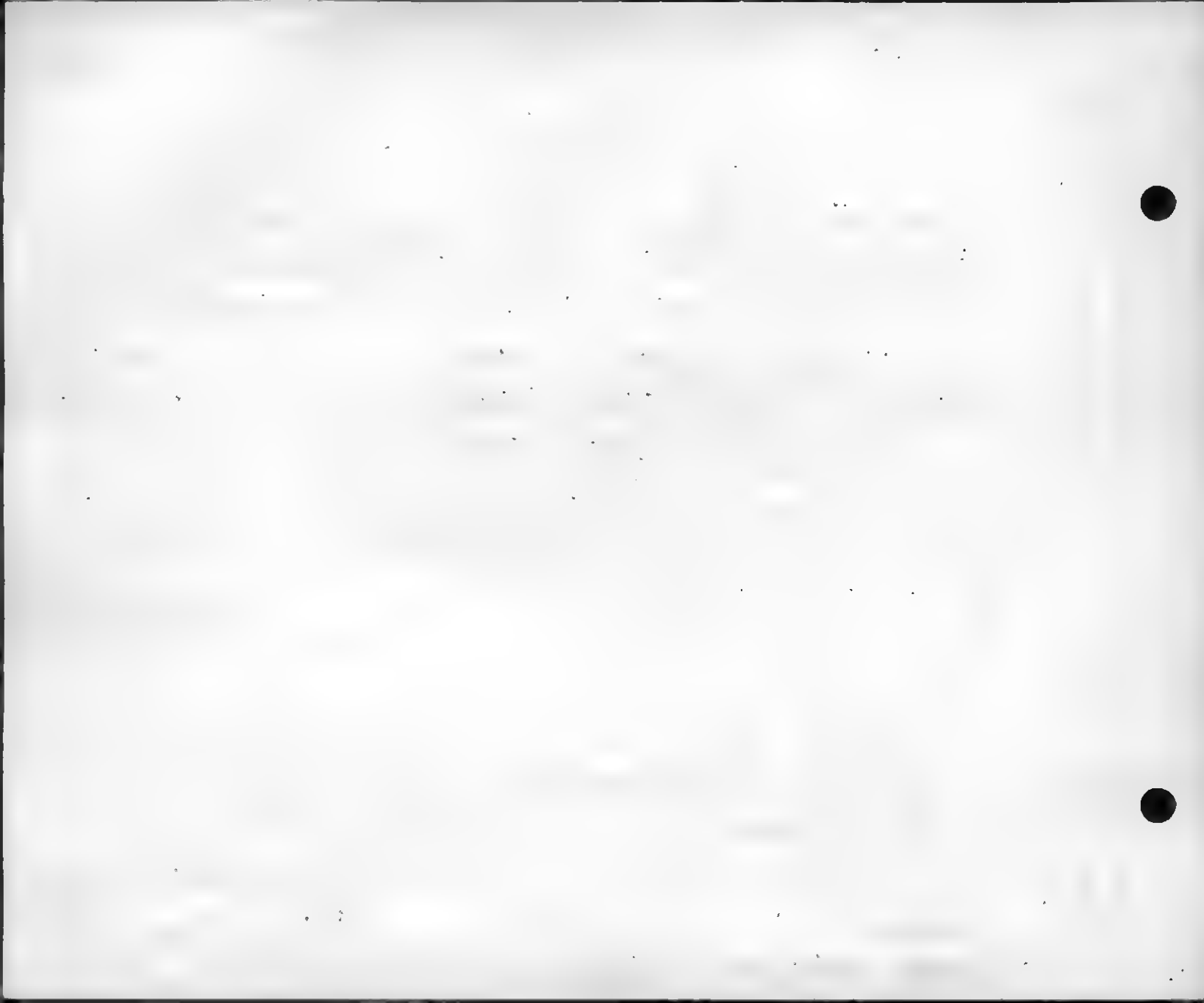
TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Clara</i>		First <i>C</i>		Middle <i>Heine</i>		Last		20. DATE OF DEATH Month <i>3</i> Day <i>23</i> Year <i>68</i>		2b HOUR <i>6:45 AM</i>	
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>1-8-8887</i>		6. AGE (In years lost birthday) <i>80</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>NEW YORK</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md					
10. CITY OR TOWN OF DEATH <i>Wheaton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Wheaton Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>home maker</i>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MD.</i>		13b. COUNTY <i>MONT.</i>		13c. CITY OR TOWN <i>Sil. Spr.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>1110 FIDLER LANE</i>			
14. FATHER'S NAME First <i>John</i>		Middle <i>Colegrove</i>		Last		15. MOTHER'S MAIDEN NAME First <i>EUNICE</i>		Middle <i>TALLMAN</i>		Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>579-60-9053</i>		17. INFORMANT <i>Miss Marie Heine</i>		Address <i>1110 FIDLER LANE SILVER SPRING MD.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>10 years</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4200</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Parkinson's disease</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No. City or Town County State							
22a. I certify that (I) (the hospital) attended the deceased from <i>1955</i> , to <i>3-23</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>3-12</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Seruch T. Kimble</i> M.D.		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>3-23-68</i>					
22d. PHYSICIAN'S NAME (Type) <i>SERUCH T. KIMBLE</i>		22e. ADDRESS <i>9801 George Avenue, Silver Spring, Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>3-26-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek</i>		23d. LOCATION (City or Town) <i>Wash DC</i>		(County)		(State)	
24. FUNERAL DIRECTOR <i>Joseph Grawley's Sons</i>		ADDRESS <i>5130 Wisconsin Ave NW</i>		CITY <i>WASH DC</i>		25a. REC'D BY REGISTRAR DATE <i>MAR 27 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

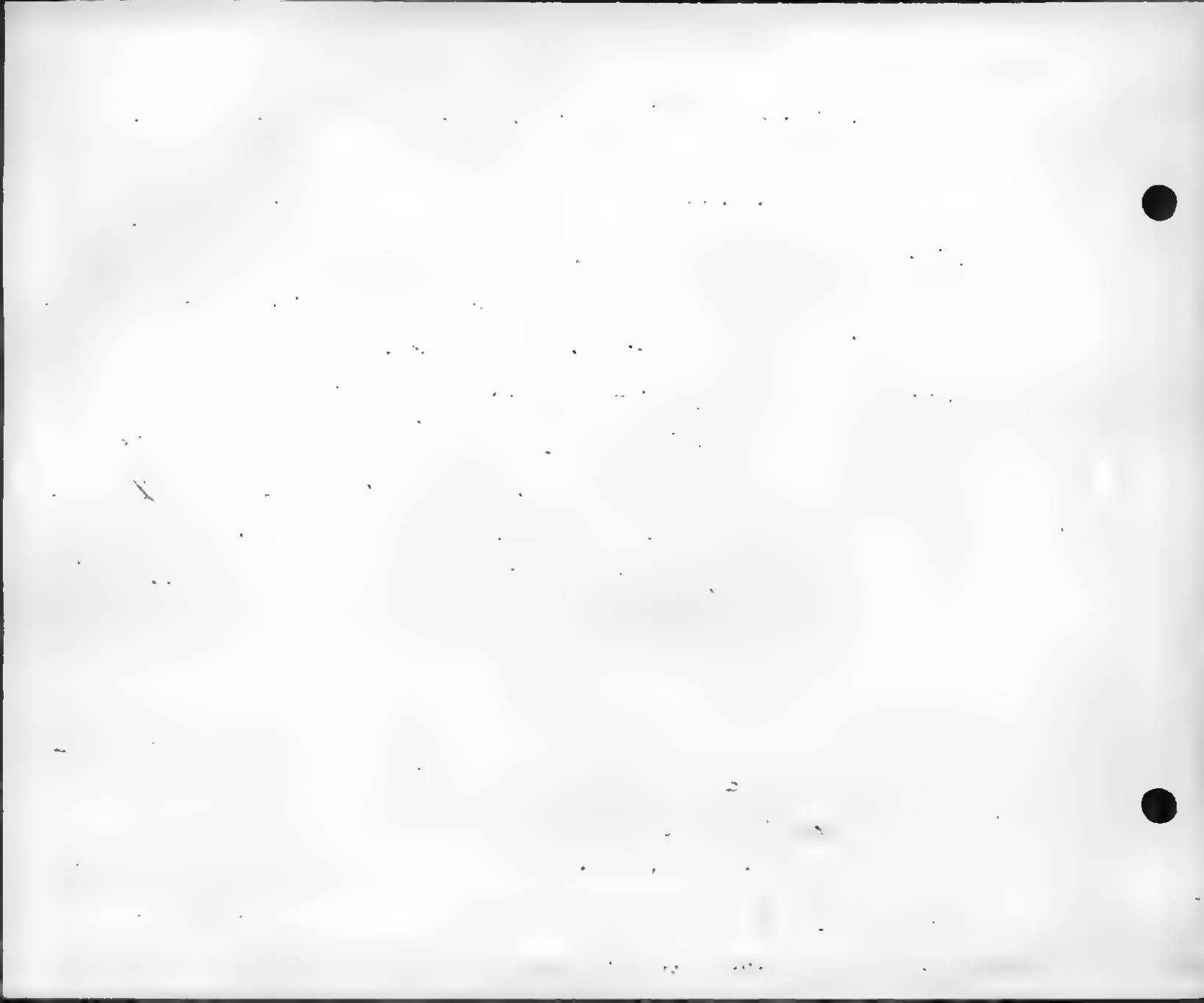
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VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Helene Corbin Heine</i>			2a. DATE OF DEATH Month <i>March</i> Day <i>4</i> Year <i>68</i>			2b. HOUR <i>10:05</i> M	
3. SEX <i>F</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH <i>3-31-80</i>		6. AGE (In years last birthday) <i>88</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>Ind.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Teacher - Piano</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Music</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>D.C.</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Washington</i> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <i>John</i> Middle <i>Corbin</i> Last <i>Heine</i>		15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>Jusell</i> Last <i>Heine</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <i>579-16-4201</i>	
17. INFORMANT <i>Son - Rolf Heine</i>		Address <i>Same as above</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis.</i>							<i>24 hrs.</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral arteriosclerosis</i>							<i>20 yrs.</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Generalized arteriosclerosis</i>							<i>25 yrs.</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Diabetes mellitus; arteriosclerotic heart disease with heart failure</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <i>19</i> P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. <i>1412</i> City or Town <i>Silver Spring</i> County <i>Montgomery</i> State <i>MD</i>			
22a. I certify that (I) (this hospital) attended the deceased from <i>1/12</i> 19 <i>68</i> , to <i>3/4</i> 19 <i>68</i> , that (I) () last saw the deceased alive on <i>3/4</i> 19 <i>68</i> , and that in (my) () opinion death occurred on the date and hour and from the causes stated above, (I) () (did not) view the body after death.							
22b. SIGNATURE <i>Donald W. Datlow, MD</i>				22c. DATE SIGNED <i>3/4/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Donald W. Datlow, M. D.</i>				22e. ADDRESS <i>823 UNIV. BLVD. W., SILVER SPRING, MD</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE <i>3/6/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		23d. LOCATION (City or Town) <i>Suitland, Maryland</i> (County) <i>Montgomery</i> (State) <i>MD</i>	
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc., Washington, D. C.</i>				25a. REC'D BY REGISTRAR <i>MAR 8 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MD350
MAY 1968
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

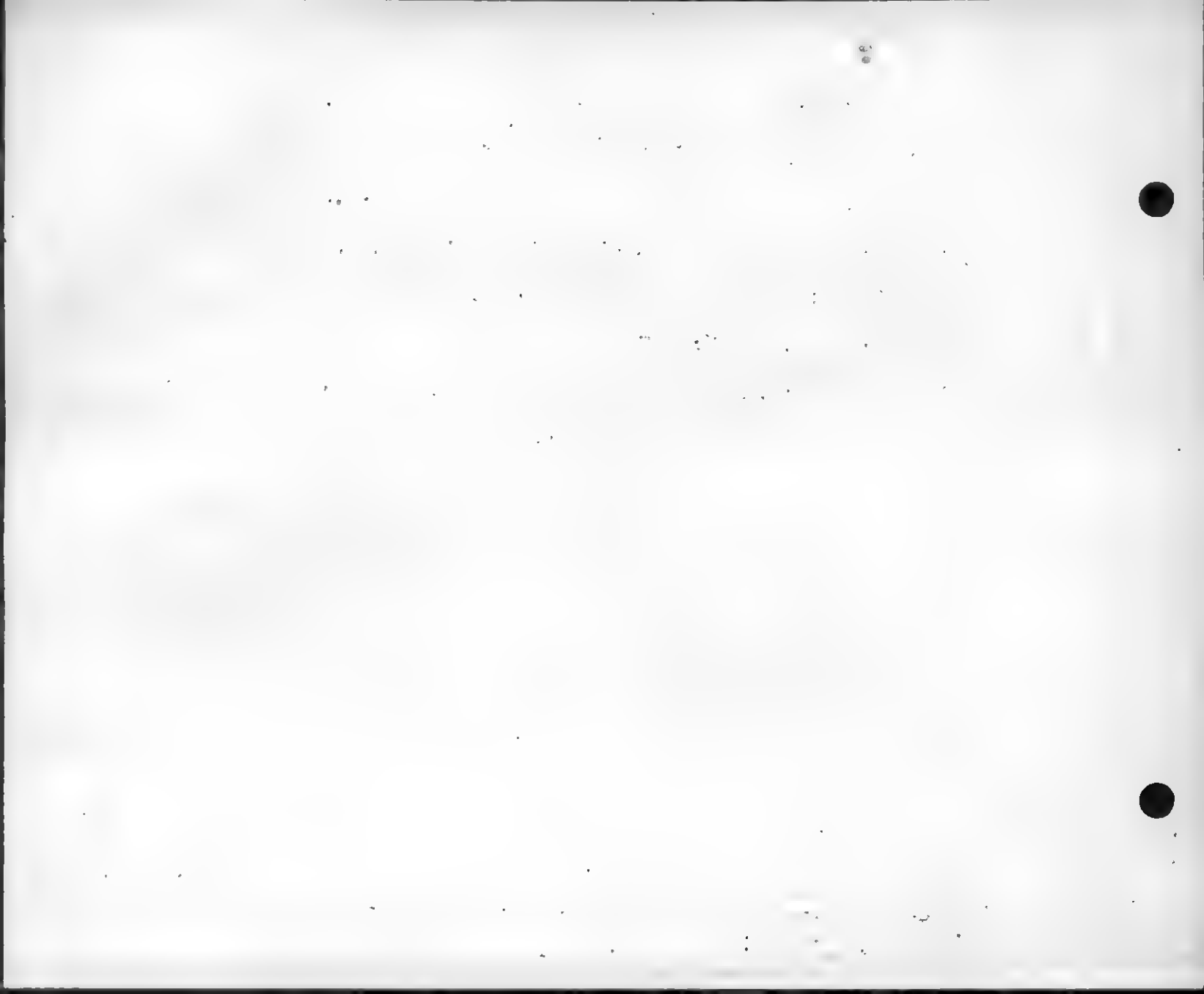
1. DECEASED-NAME (Type or print) Edwin B. Henry		2a. DATE OF DEATH Month March Day 16 Year 1968		2b. HOUR 7:00 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH 10-8-1887		6. AGE (In years last birthday) 80 YRS
7a. BIRTHPLACE (State or foreign country) N.Y.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Kensington, Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kensington Garden Sanitorium		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Gov.	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Montgomery	13b. CITY OR TOWN Silver Spring	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2601 Belmont Rd.	
14. FATHER'S NAME First James J. Middle Byrnes		15. MOTHER'S MAIDEN NAME First Abigail Middle Mahoney		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) Unknown yes		16b. SOCIAL SECURITY NO 124-10-8407	17. INFORMANT Joseph J. Byrnes Address 115-10 210th St. Cambria Heights, N.Y.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 7109 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 Minutes
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 1201				
19a. DATE OF OPERATION None	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour None A.M. Month None Day None Year 1968 P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) None		
21d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work or while <input type="checkbox"/> at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) None	21f. LOCATION Street or R.F.D. No. 2222 City or Town Washington County D.C. State D.C.		
22a. I certify that (I) (this hospital) attended the deceased from August 1967 , to March 16, 1968 , that (I) (we) last saw the deceased alive on March 19, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE James M. Loftus		DEGREE MD	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED MARCH 16, 1968
22d. PHYSICIAN'S NAME (Type) James M. Loftus		22e. ADDRESS 545 Connecticut Ave N.W. Wash. D.C.		
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	23b. DATE 3/20/68	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.	23d. LOCATION (City or Town) (County) (State) Washington, D.C.	
24. FUNERAL DIRECTOR The S.H. Hines Co.		25a. REC'D BY REGISTRAR DATE MAR 20 1968		25b. REGISTRAR'S SIGNATURE Charles Judge



TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Charles Melchoir Herrmann		2a. DATE OF DEATH March Month 10 Day 68 Year		2b. HOUR 1142 A M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH Sep 12 1896	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) US NAVAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during past 12 months, even if retired) U. S. NAVY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY VALLEY LEE		13c. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last FERDINAND M. HERRMANN		15. MOTHER'S M.A.D.E.N NAME First Middle Last MARY METZ			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. 220-44-1388		17. INFORMANT Address Lillian A. Herrmann Valley Lee, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease in congestive failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pulmonary emphysema					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (X) (this hospital) attended the deceased from March 6 , 19 68 , to March 10 , 19 68 , that (X) (we) last saw the deceased alive on March 10 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert J. Kinney, M.D.		22c. DATE SIGNED 11 Mar 1968		22d. PHYSICIAN'S NAME (Type) Robert J. Kinney, M. D.	
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b. DATE MARCH 13, 1968		23c. NAME OF CEMETERY OR CREMATORY St. Georges Catholic Church, Valley Lee, Maryland	
24. FUNERAL DIRECTOR MATTINGLY FUNERAL HOME, Leonardtown, Md.		25a. REC'D BY REGISTRAR MAR 13 1968		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) CARL WILLIAM HERRON			2a DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 3 3 19 68 3P M		
3 SEX Male	4 RACE White	5 DATE OF BIRTH 3/20/63	6 AGE (In years last birthday) 4 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	7c DATE PRONOUNCED DEAD Month March Day 3 Year 19 68 3P M
7a BIRTHPLACE (State or foreign country) W. Va.		7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md
10 CITY OR TOWN OF DEATH Silver Spring MD		11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give street address) Holy Cross Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Child	
13a USUAL RES DENCE (Where deceased lived, if institution Residence before admisson) STATE Maryland		13b COUNTY Montgomery	13c CITY OR TOWN Rockville	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 4604 Bel Pre Rd.
14 FATHER'S NAME First Frank Middle Herron, Last Jr.			15 MOTHER'S MAIDEN NAME First Josephine Middle Flickinger Last Flickinger		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO		17 INFORMANT Father, ADDRESS Frank Herron, Jr. 4604 Bel Pre Rd. Rkvl., Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Extreme Injuries DUE TO, OR AS A CONSEQUENCE OF (b) including intracranial Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) 14.7 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PR MARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year 10:00 A.M. 3-3-1968		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II Item 18.) Child ran into street in front of auto	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street		21f LOCATION Street or RFD No. Bel Pre Rd. Mr. Aron City or Town Rockville County Montgomery State Md	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Belden R. Reap MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED MAR. 3, 1968	
EXAMINER'S NAME (Type) BELDEN R. REAP		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, P.O. Box, or RFD) 4604 Bel Pre Rd. Rkvl., Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 3/6/68		23c NAME OF CEMETERY OR CREMATORY Pottstown West End Cemetery	
24 FUNERAL DIRECTOR W. J. Huntemann & Son		ADDRESS 5132 Georgia Ave N.W.		25a REC'D BY REGISTRAR MAR 7 1968	
				25b REGISTRAR'S SIGNATURE [Signature]	



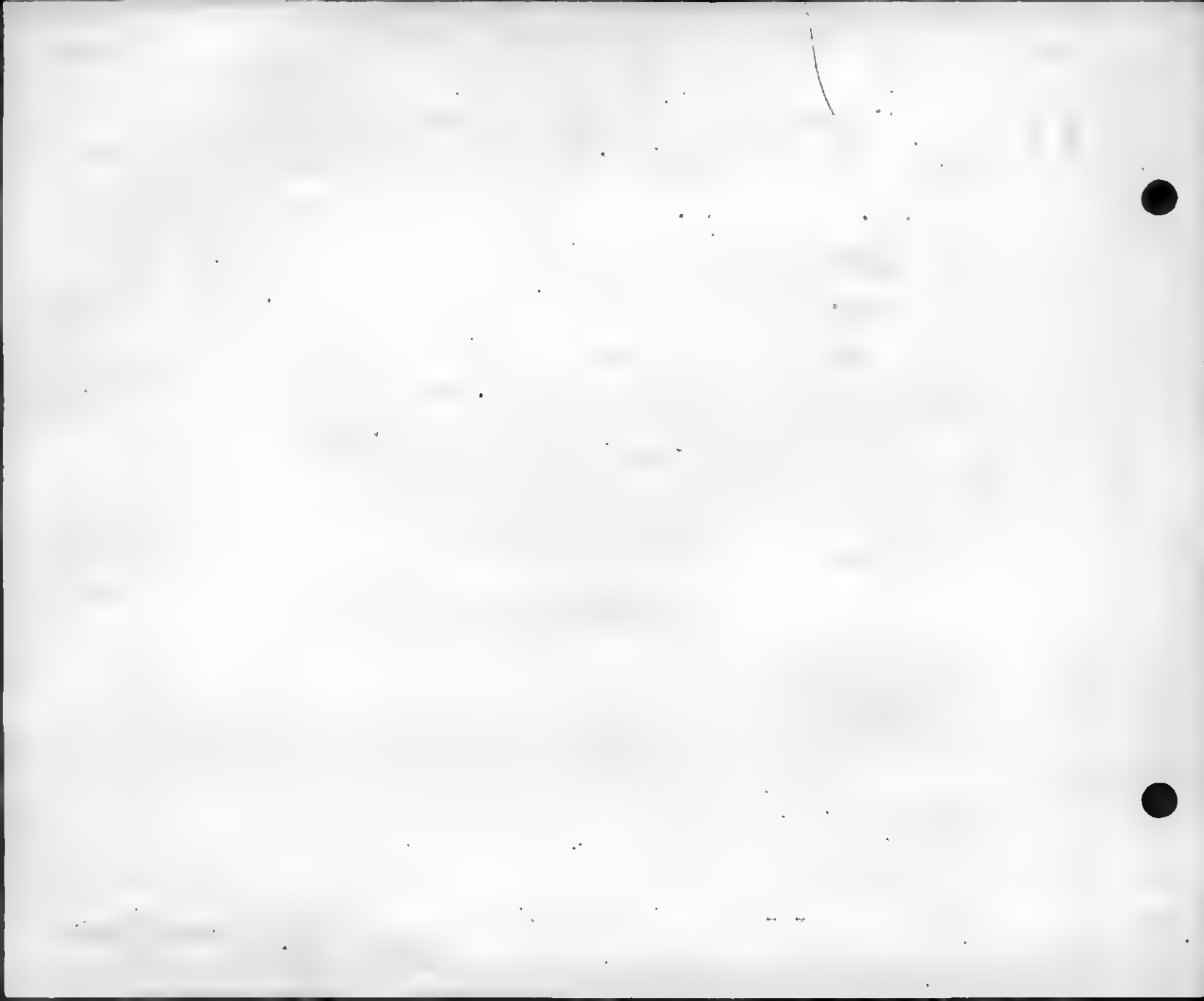
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

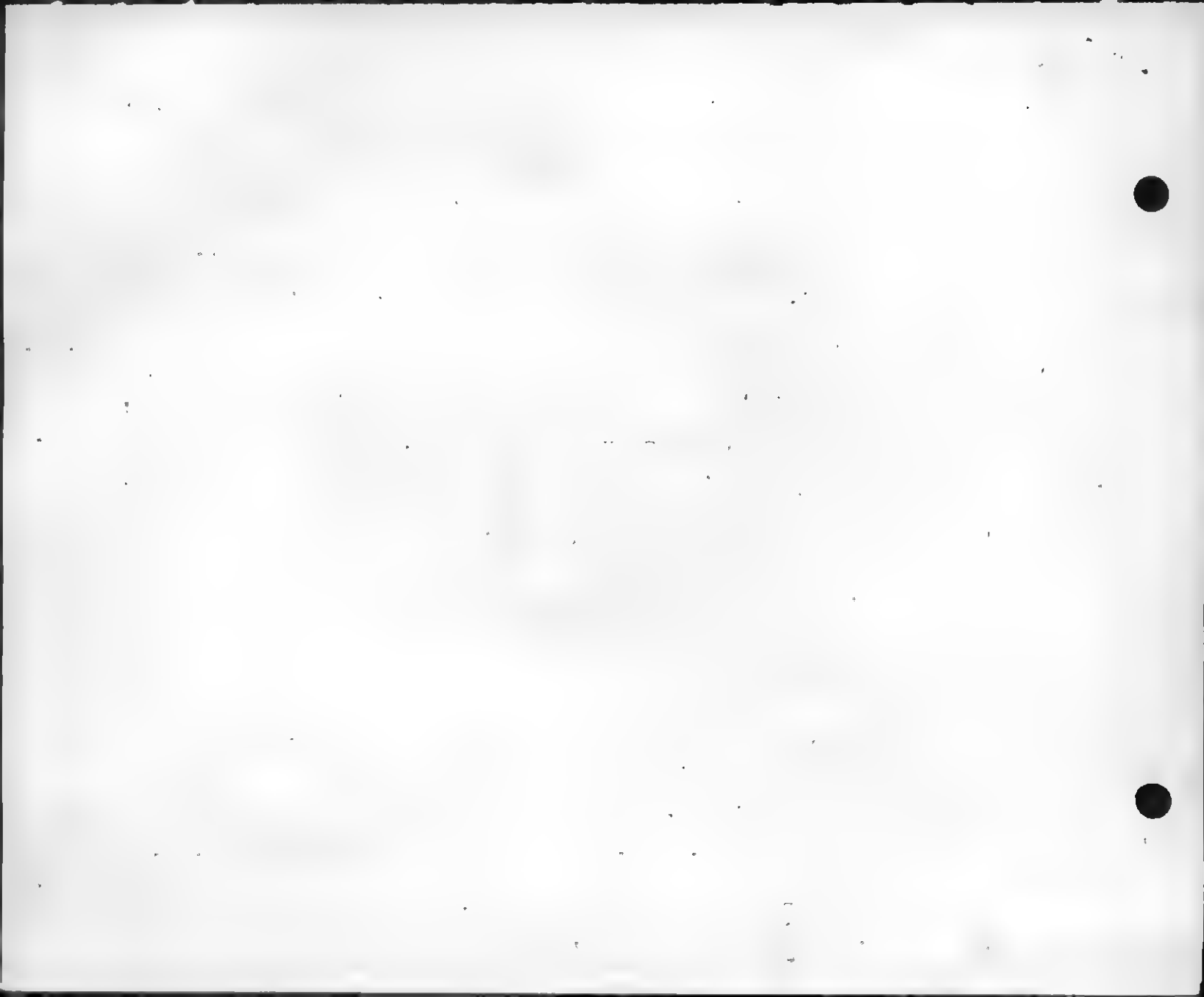
1 DECEASED NAME (Type or Print) IVAN MARTIN HIGH		First Middle Last		2a DATE KNOWN OF DEATH Month Day Year 3-29 1968		2b HOUR 5:50 PM	
3 SEX Male	4 RACE Cauc	5 DATE OF BIRTH MAY 7, 1906	6 AGE (in years) 61 YRS	7 UNDER 24 HRS MONTHS DAYS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year 3 29 1968		2d HOUR 5:50 PM
7a BIRTHPLACE (State or foreign country) V. Va.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md.	
10 CITY OR TOWN OF DEATH Gaithersburg		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) #4 E. DIAMOND AVE.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) BARBER		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Montgomery		13c CITY OR TOWN Gaithersburg		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 4 E. Diamond Ave;		14 FATHER'S NAME John Harper High		15 MOTHER'S MAIDEN NAME Sarah L. Huffman			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO 218-12-5463		17 INFORMANT Mrs. Joann Swisher Cumberland, Md.		ADDRESS	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute Myocardial Infarct DUE TO OR AS A CONSEQUENCE OF (b) Coronary occlusion DUE TO OR AS A CONSEQUENCE OF (c) Atherosclerosis Conditions, if any, which give rise to immediate cause (a), stating the underlying cause lost				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item B)			
2d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> OR NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No.		City or Town County State	
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Reap		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED 3/30/1968	
EXAMINER'S NAME (Type) BELDEN R. REAP		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, City, and County)			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 4-2-68		23c NAME OF CEMETERY OR CREMATORY Potomac V.M. Park		23d LOCATION (City or Town) (County) (State) Keyser, W. Va.	
24 FUNERAL DIRECTOR Harry W. Haight		ADDRESS Sylkesville, Md.		25a REC'D BY REGISTRAR APR 2 - 1968		25b REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chevy Chase						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chevy Chase					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 24 Hesketh Street						d. STREET ADDRESS 24 Hesketh Street					
3. NAME OF DECEASED (Type or print) First KARL Middle HOFFMAN Last						4. DATE OF DEATH Month Day Year Mar. 16, 19 68					
5. SEX Male		6. COLOR OR RACE Cauc.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 9, 1893		9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Broker				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Missouri			12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME Jacob Hoffman						14. MOTHER'S MAIDEN NAME Ina Snyder					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW I				16. SOCIAL SECURITY NO. 577-48-2750		17. INFORMANT Wife		Address Miriam R. Hoffman Same as Item 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE MYELOMA 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BRONCHITIS, Acute DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 3 YEARS 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 203X											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1958 , 1958 , to MAR. 16, 1968 , that (II) (we) last saw the deceased alive on MAR. 15 1968 , and that death occurred at 3 PM , from the causes and on the date stated above.											
22a. SIGNATURE Philip R. James						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) PHILIP R. JAMES						22d. ADDRESS WASHINGTON CLINIC WASHINGTON, D. C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b. DATE THEREOF 3-18-68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory			23d. LOCATION (City, town or county) (State) Suitland, Maryland			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland						25a. REC'D BY REGISTRAR DATE MAR 26 1968		25b. REGISTRAR'S SIGNATURE			



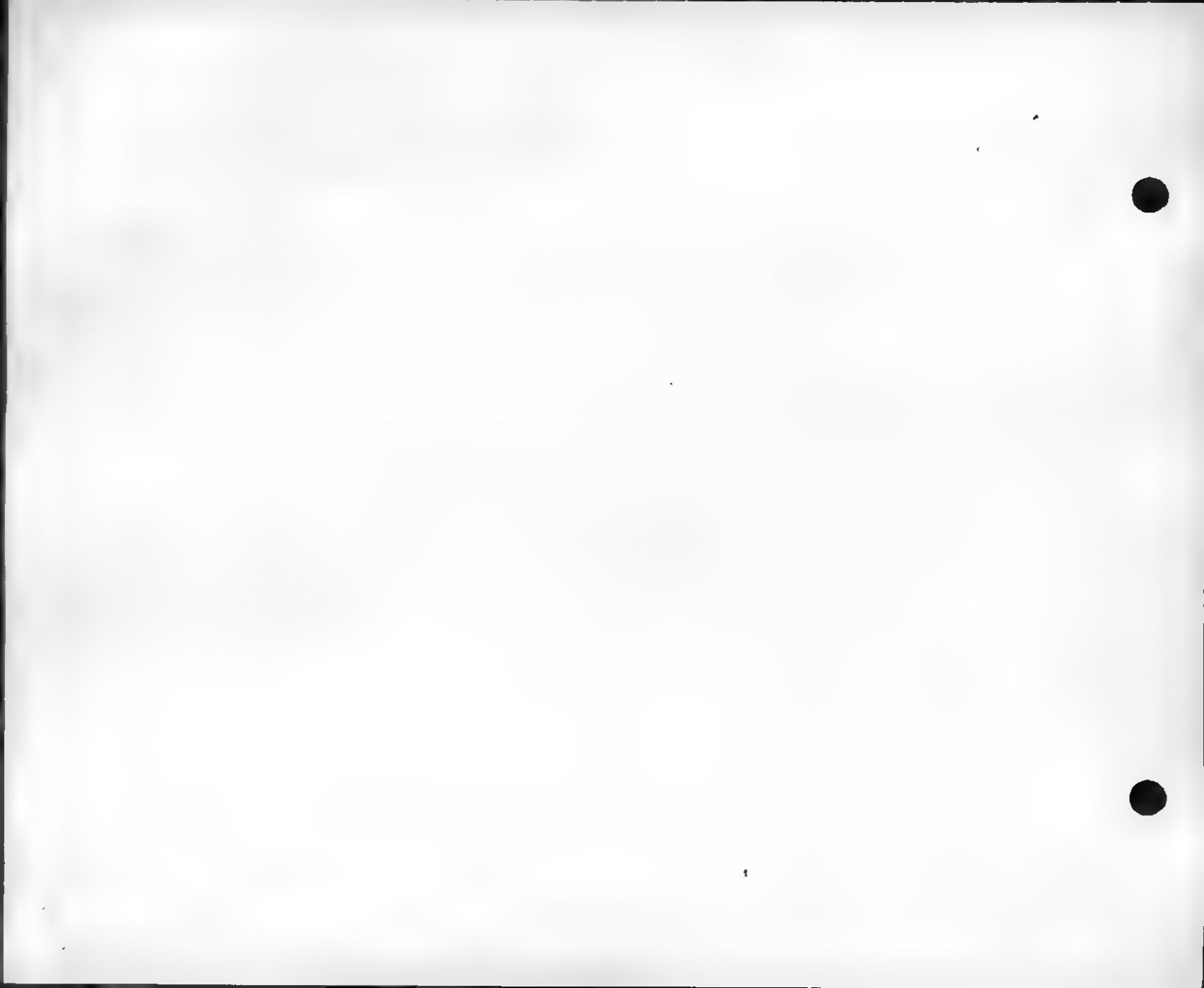
CERTIFICATE OF DEATH

J4841

1. DECEASED NAME (Type or print) <i>Peter</i> First <i>L</i> Middle <i>Hoffman</i> Last			2a. DATE OF DEATH Month <i>March</i> Day <i>28</i> Year <i>1968</i>			2b. HOUR <i>4:45</i> AM	
3. SEX <i>Male</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>1/6/1917</i>		6. AGE (In years last birthday) <i>51</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>West Va</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Electrical</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>P.E.P. Co</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Greenbelt</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <i>Meadowbrook Estates</i>		14. FATHER'S NAME First <i>Lawrence</i> Middle <i>Hoffman</i> Last		15. MOTHER'S MAIDEN NAME First <i>Zana</i> Middle <i>K.</i> Last <i>Guimp</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> no <input checked="" type="checkbox"/> (If yes give war or dates of service) <i>W W II</i>		16b. SOCIAL SECURITY NO. <i>235-50-9623</i>		17. INFORMANT <i>Wife Elouse Hoffman</i>		Address <i>Same as above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Pulmonary edema</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Myocardial infarct.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary Thrombosis</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7 hours</i> <i>12 hours</i> <i>12 hours</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) <i>4109</i>							
19a. DATE OF OPERATION <i>4-28-68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (i) (this hospital) attended the deceased from <i>July</i> , 1956, to <i>3-28</i> , 1968, that (i) (we) last saw the deceased alive on <i>3-28</i> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Seruch T. Kimble</i> M.D. DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>3-28-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Seruch T. Kimble</i>		22e. ADDRESS <i>9801 Georgia Avenue, Silver Spring, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4/1/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville, Montg. Md.</i>	
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i>		ADDRESS <i>1331 Rock Pike</i>		25a. REC'D BY REG STRAR DATE <i>APR 3 - 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
		<i>Rockville, Md.</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, including funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

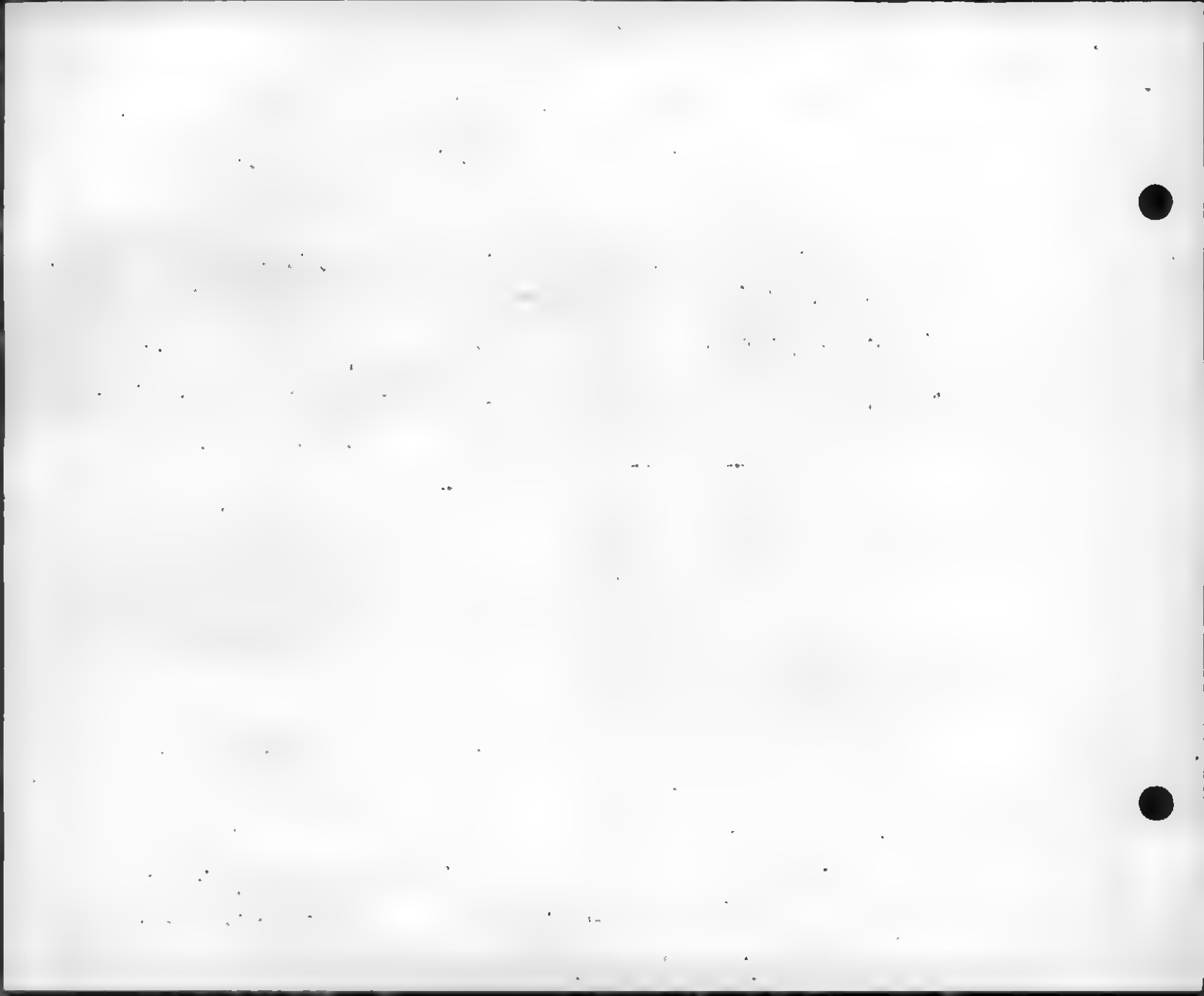
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VR A15 (4)
30M REV 1/68

MD 2350
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH 0434

1 DECEASED-NAME (Type or print) First Middle Last Mary Lee HOLLENBACK			2a DATE OF DEATH Month Day Year March 17 1968		2b. HOUR 510A M
3 SEX Female	4 RACE Caucasian	5. DATE OF BIRTH Dec. 19, 1939		6 AGE (n years last birthday) 28 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Indiana	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery Md		
10 CITY OR TOWN OF DEATH Bethesda	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) State Department		12b. KIND OF BUSINESS OR INDUSTRY Govt.
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Indiana		13b. COUNTY Kokomo	13c. CITY OR TOWN Kokomo	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2508 S. Walbasch
14 FATHER'S NAME First Middle Last Clarence Hollenbeck			15. MOTHER'S MAIDEN NAME First Middle Last Wilma Bryant		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 328 32 9116	17. INFORMANT Kokomo, Ind. Address Mrs. Wilma Hollenbeck, 2508 S. Walbasch		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma-primary adrenal or ovary with metastases to liver, bone, lung, lymph nodes, pancreas, and kidney Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (X) (this hospital) attended the deceased from Oct. 1, 1968 , to Mar. 17, 1968 , that (X) (we) last saw the deceased alive on Mar. 17, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.					
22b. SIGNATURE D. N. Holt		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED March 18, 1968	
22d. PHYSICIAN'S NAME (Type) D. N. HOLT		22e. ADDRESS Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3-20-68	23c. NAME OF CEMETERY OR CREMATORY Thrailkill Cemetery	23d. LOCATION (City or Town) (County) (State) Swayzee, Indiana		
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home		ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		25a. REC'D BY REGISTRAR DATE MAR 26 1968	
				25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

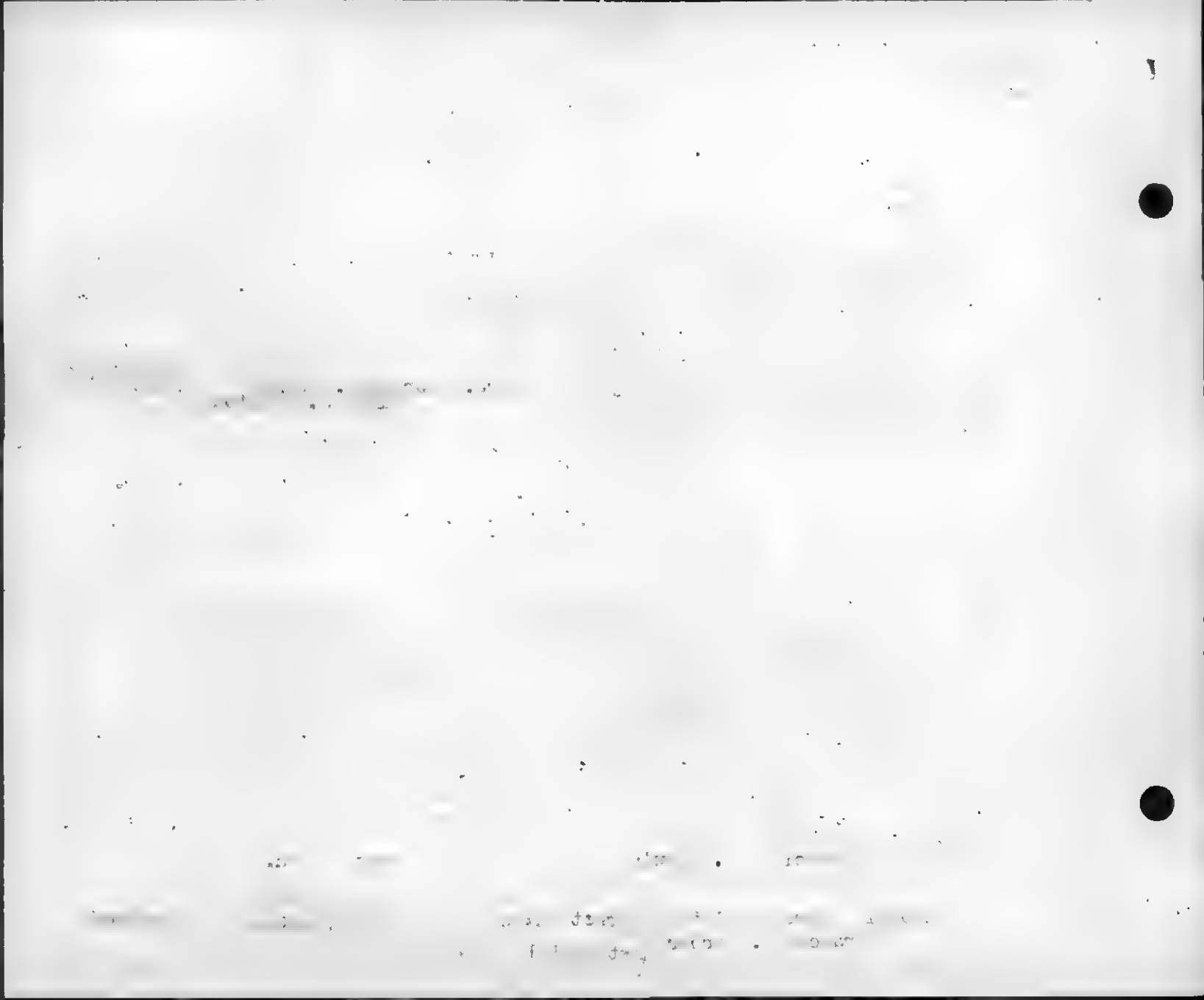


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Items #2a, 13a, c, e, & 23c, Film #G399 4/1/68 km 04357
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last Ruth Howard House			2a. DATE OF DEATH Month Day Year March 23 1968		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH November 10, 1879		6. AGE (In years lost b rthday) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Iowa	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Gravestone Grave Foundation		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Nurse	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Missouri	13b. COUNTY Springfield	13c. CITY OR TOWN Springfield	13d. HOME CITY (L.M.T.S?) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3138 S. Dayton	
14. FATHER'S NAME First Middle Last Raylan S. Howard	15. MOTHER'S MAIDEN NAME First Middle Last Gynette Strong		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No		
16b. SOCIAL SECURITY NO. 217-52-8284		17. INFORMANT Mrs. Georgia H. Brunner		Address Springfield Missouri	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> DUE TO, OR AS A CONSEQUENCE OF <u>CEREBRAL ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>TERMINAL</u> <u>YRS.</u> <u>YRS.</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 1966</u> to <u>23 Mar 1968</u> , that (I) (we) last saw the deceased alive on <u>23 Mar 1968</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Donald R. Lewis MD		22c. DATE SIGNED 23 Mar 68		22d. PHYSICIAN'S NAME (Type) Donald R. Lewis	
22e. ADDRESS Olney Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE March 24 1968		23c. NAME OF CEMETERY OR CREMATORY Forest Lawn Hills	
23d. LOCATION (City or Town) Madison		(County) Wisconsin		(State)	
24. FUNERAL DIRECTOR Francis H. Barber		ADDRESS Laytonville Md.		25a. REC'D BY REGISTRAR DATE MAR 26 1968	
25b. REGISTRAR'S SIGNATURE James Judge					

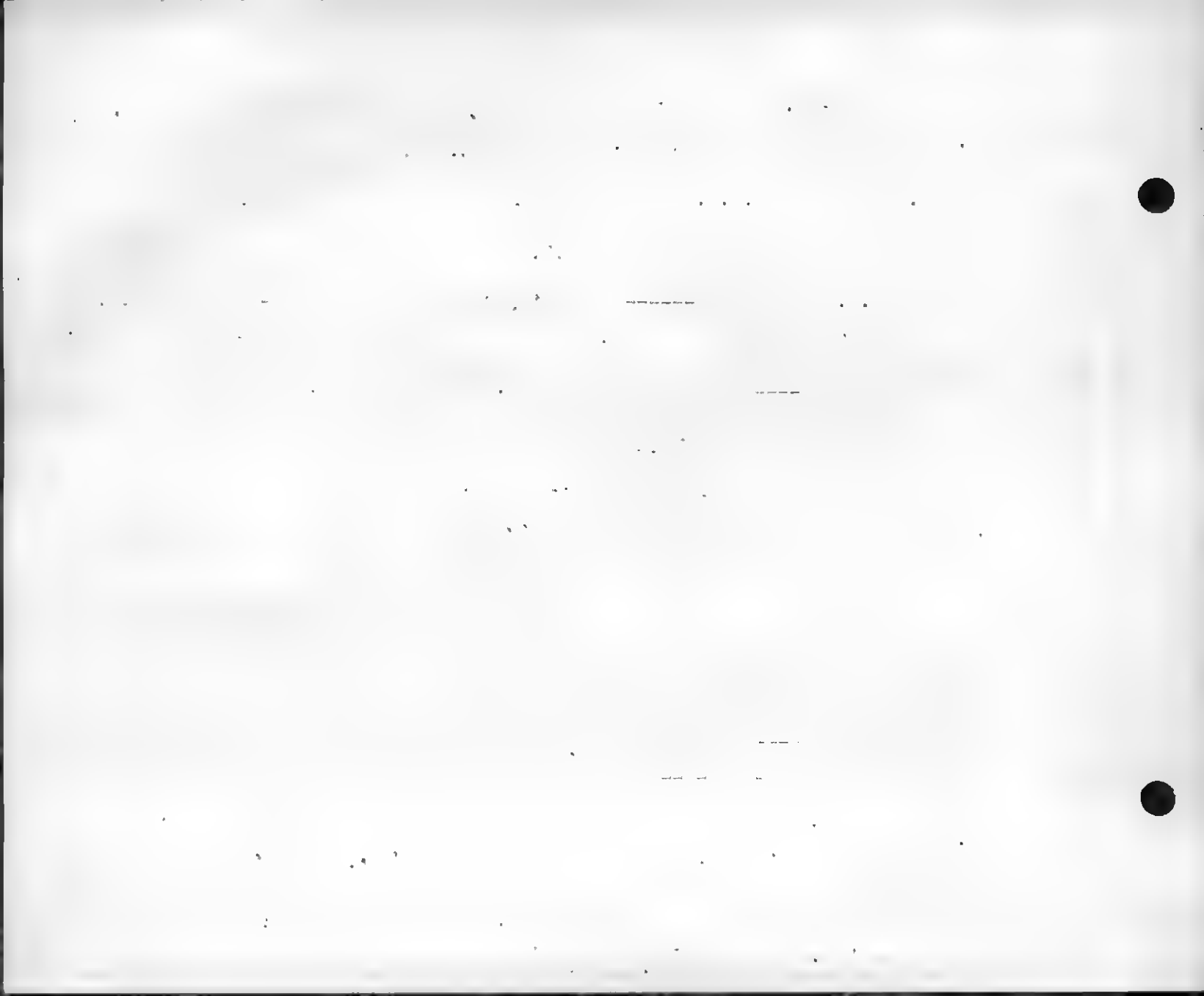


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Lesley		First GAW	Middle Hoyos	2a. DATE OF DEATH Month MARCH Day 11 Year 1968	2b. HOUR 7:30 PM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH Feb. 18, 1885		6. AGE (In years last birthday) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Penna.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Kensington	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll Hall N.H.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY At Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE D.C.	13b. COUNTY Washington	13c. CITY OR TOWN Washington	13d. INS DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3901 - 47th St., N.W.	
14. FATHER'S NAME First Alexander Middle Moore Last Gaw	15. MOTHER'S MAIDEN NAME First Mary Middle ----- Last Brandon				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service) -----	16b. SOCIAL SECURITY NO. 578-62-0173	17. INFORMANT Address Mrs. Robert L. Sage, Dtr., Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Acute myocardial Failure DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 hrs 4 months 12 years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1/14/68 , 19 68 , to 5/11 , 19 68 , that (I) (we) last saw the deceased alive on 5/11 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE S.A. Thomas M.D.		22c. DATE SIGNED 5/11/68	22d. ADDRESS 4301 48th St NW Washington DC		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/14/68	23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	23d. LOCATION (City or Town) (County) (State) Rockville, Maryland		
24. FUNERAL DIRECTOR Jos. Gawler's Sons, Washington, D.C. 20016		25a. REC'D BY REGISTRAR MAR 14 1968	25b. REGISTRAR'S SIGNATURE William J. Judge		



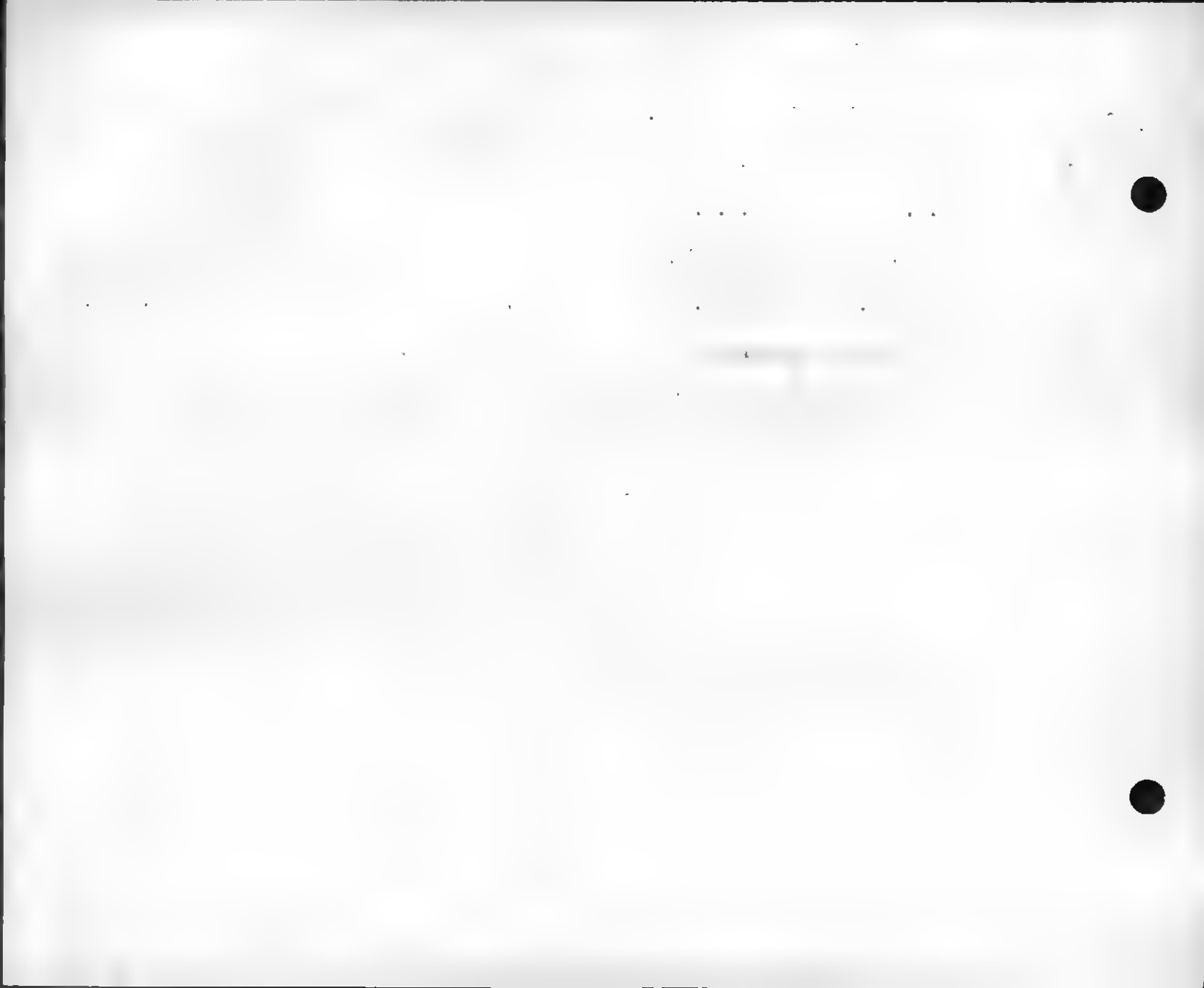
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Virginia C. Hurley			2a. DATE OF DEATH Month March Day 20 Year 1968			2b. HOUR 3: P.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH 10/7/93		6. AGE (In years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS 74 DAYS 74 HOURS 74 MIN		
7a. BIRTHPLACE (State or foreign country) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Telephone operator			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD D.C.			13b. COUNTY Montgomery		13c. CITY OR TOWN Wash.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 14213 Ingomae St. N.W.	
14. FATHER'S NAME First Middle Last Robert Henry Leathers				15. MOTHER'S MAIDEN NAME First Middle Last Bettie F. Nalls						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes, no, or (unknown) No				16b. SOCIAL SECURITY NO 220/54/0377		17. INFORMANT Betty Jane Cox		Address 13905 Bower Dr. Rockville, Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left hemiplegia, severe DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arteriosclerosis, generalised, severe DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension, severe & Diabetes Mellitus PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Thrombosis, arterial, right leg, with gangrene									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 days 5 yrs 10 yrs	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 1946 , to March 20, 1968 , that (I) (we) last saw the deceased alive on March 20, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Stewart Clapp M.D. DEGREE Stewart Clapp M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED March 20, 1968		
22d. PHYSICIAN'S NAME (Type) Stewart Clapp M.D.						22e. ADDRESS 4940 Chevy Chase Dr., Chevy Chase, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3-23-68		23c. NAME OF CEMETERY OR CREMATORY Columbia Gardens		23d. LOCATION (City or Town) (County) (State) Arlington Va.				
24. FUNERAL DIRECTOR Jones Funeral Home Arlington Va						25a. REC'D BY REGISTRAR Charles Jones		25b. REGISTRAR'S SIGNATURE Charles Jones		

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VR AT5 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 8 & 9 Film G398 3/13/68

CERTIFICATE OF DEATH

14344

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>NALLS NURSING HOME</u>				d. STREET ADDRESS <u>1200 PROSPECT AVE.</u>			
3 NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>E.</u> Last <u>HYATT</u>				4 DATE OF DEATH Month <u>MARCH</u> Day <u>9</u> Year <u>1968</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 27, 1881</u>	9. AGE (In years last birthday) <u>86</u> yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>INDEXVILLE VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN RILEY Gibson</u>				14. MOTHER'S MAIDEN NAME <u>NANCY ANN PRICE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-48-8004</u>		17. INFORMANT Address <u>1200 PROSPECT TAKOMA PARK MD.</u> <u>DR. W.W. EASTMAN</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Atherosclerosis, Generalized</u> <u>4404</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>4500</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Breast</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>66</u> , to <u>March</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>March 8, 1968</u> , and that death occurred at <u>10:30 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>James M. Whitlock MD</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-9-68</u>	
22c. PHYSICIAN'S NAME (Type) <u>James M. Whitlock</u>				22d. ADDRESS <u>2272 Conell Ave Takoma Park Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>3-12-1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		23d. LOCATION (City or Town) (County) (State) <u>ARLINGTON VA.</u>	
24. FUNERAL DIRECTOR <u>Arthur Walters</u>				25a. REC'D BY REG STRAR DATE <u>MAR 13 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



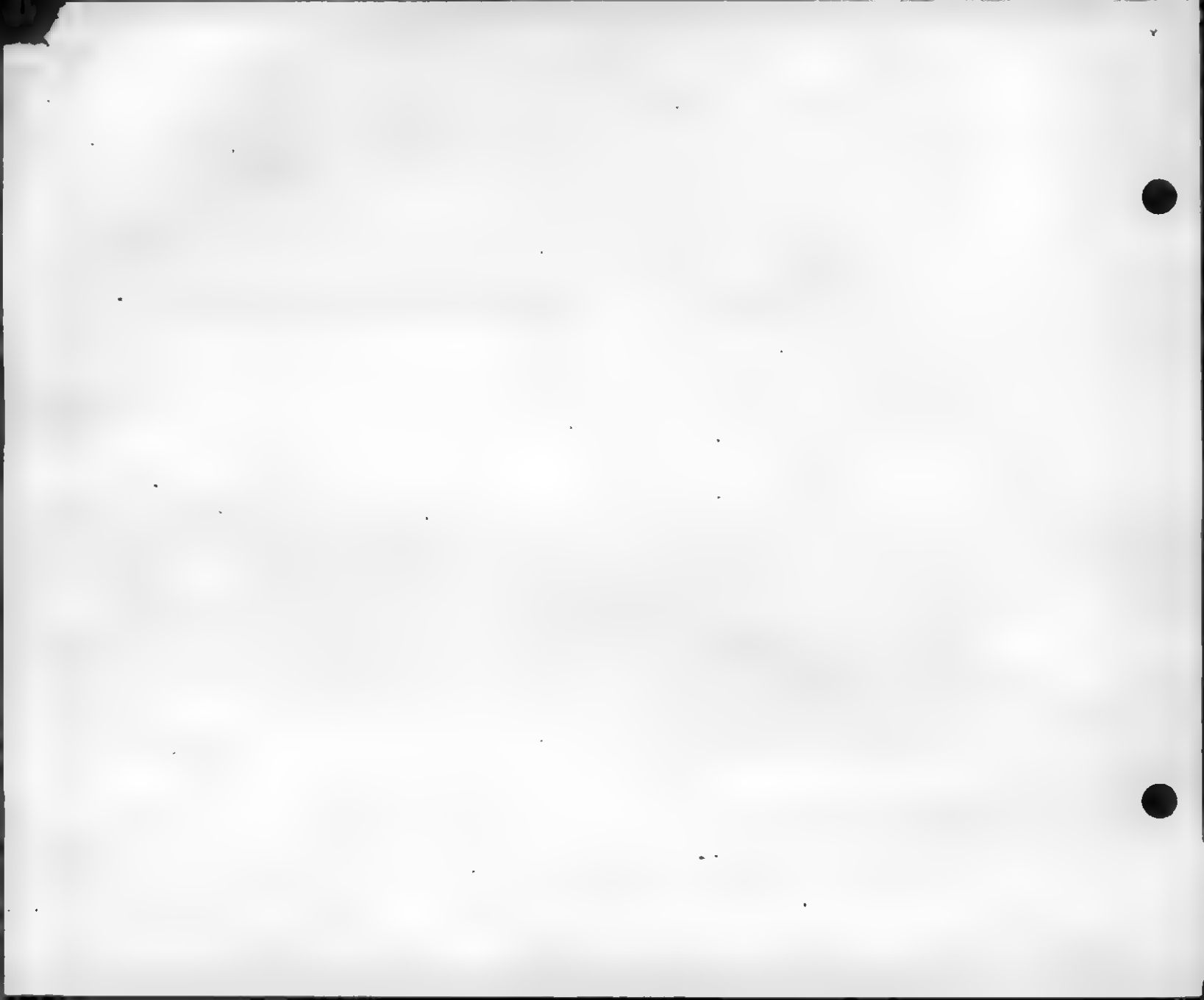
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) WILLIAM Wilbur IAGER			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year March 1 1968			2b. HOUR 10:37 PM		
3. SEX Male	4. RACE White	5. DATE OF BIRTH 9/2/09	6. AGE 58 YRS	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month March Day 1 Year 1968		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Auto Salesman		12b. KIND OF BUSINESS OR INDUSTRY Auto Sales
13a. USUAL RESIDENCE (Where deceased lived, if not in institution or residence before admission) STATE Maryland			13b. COUNTY Prince George's			13c. CITY OR TOWN Hyattsville		
14. FATHER'S NAME William A Iager			15. MOTHER'S MAIDEN NAME Susie - McChesney			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		
16b. SOCIAL SECURITY NO. WWLI			17. INFORMANT Mrs. Helen I Dameron			18. ADDRESS 11455 Cherry Hill Rd Beltsville, Md.		
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Insufficiency								
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Heart Disease								
DUE TO, OR AS A CONSEQUENCE OF (c) 								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Belden R. Beap			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 3/2/1968		
EXAMINER'S NAME (Type) BELDEN R. BEAP MD			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (City or town, county)		
23a. BURIAL CREMATION REMOVAL (Specify) Burial			23b. DATE 3/4/68			23c. NAME OF CEMETERY OR CREMATION George Washington		
24. FUNERAL DIRECTOR Francis Gasch's Sons			ADDRESS Hyattsville Prince George Md.			25a. REC'D BY REGISTRAR MAR 6 1968		
						25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last NELLIE MYRTLE INGRAHAM			2a. DATE OF DEATH Month Day Year MARCH 20 1968			2b. HOUR 10:40 AM			
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH 5-12-83		6 AGE (In years lost birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) CANADA		7b. CITIZEN OF WHAT COUNTRY? CANADIAN		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.			
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON SAN. HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 313 CARL ST.	
14. FATHER'S NAME First Middle Last George GREEN			15. MOTHER'S MAIDEN NAME First Middle Last Eliza Warren						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO.		17. INFORMANT Address HOSPITAL CHART WASHINGTON SAN					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> 1124 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: <u>4-2-68</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Gastrointestinal Hemorrhage - etiology undetermined</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 3/10, 1968, to 3/20, 1968, that (I) (we) last saw the deceased alive on 3-20-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Joseph E. Smith Jr. Md				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-20-68			
22d. PHYSICIAN'S NAME (Type) Joseph E. Smith Jr.				22e. ADDRESS Bartonsville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-22-68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland			
24. FUNERAL DIRECTOR Robert A. Humphrey				ADDRESS Beltsville, Md.		25a. REC'D BY REGISTRAR DATE MAR 26 1968		25b. REGISTRAR'S SIGNATURE Charles J. Jones	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 Film 399 3-29-68 and 4
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR A		
Andrew		Anthony	Izing		March 14 1968		8:35 AM		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Male	White		19 October 1918		49 YRS.				
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Pennsylvania	USA				Montgomery Md				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Bethesda		Clinical Center, N.I.H.		Laborer		Sheet Metal			
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. RES. OF CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Pennsylvania				Windber		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1818 Somerset Avenue	
14. FATHER'S NAME		15 MOTHER'S MAIDEN NAME							
First Middle Last		First Middle Last							
Stephen		Izing		Mary Zabrosky					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT The Medical Records Address					
Yes 1941		192-01-8634		The Clinical Center, Bethesda, Maryland 2001					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Consecutive Heart Failure</u>								2 1/2 years	
DUE TO, OR AS A CONSEQUENCE OF <u>Pulmonary Anthracosilicosis</u>									
(Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost)									
(b) <u>Chronic Myelogenous Leukemia / Blastoid Crisis</u>								2 1/2 years	
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic myelogenous leukemia - blastic crisis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from 11 January, 1968, to 14 March, 1968, that (X) (we) last saw the deceased alive on 14 March 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Michael Emmer, M.D.</u>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 14 March 1968	
22d. PHYSICIAN'S NAME (Type) Michael Emmer, MD.				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		3-15-1968				WINDBER PA			
24. FUNERAL DIRECTOR <u>Wm. Chambers Co 1400 Chapin St. Wash. D.C.</u>				25a. REC'D BY REGISTRAR DATE MAR 18 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			



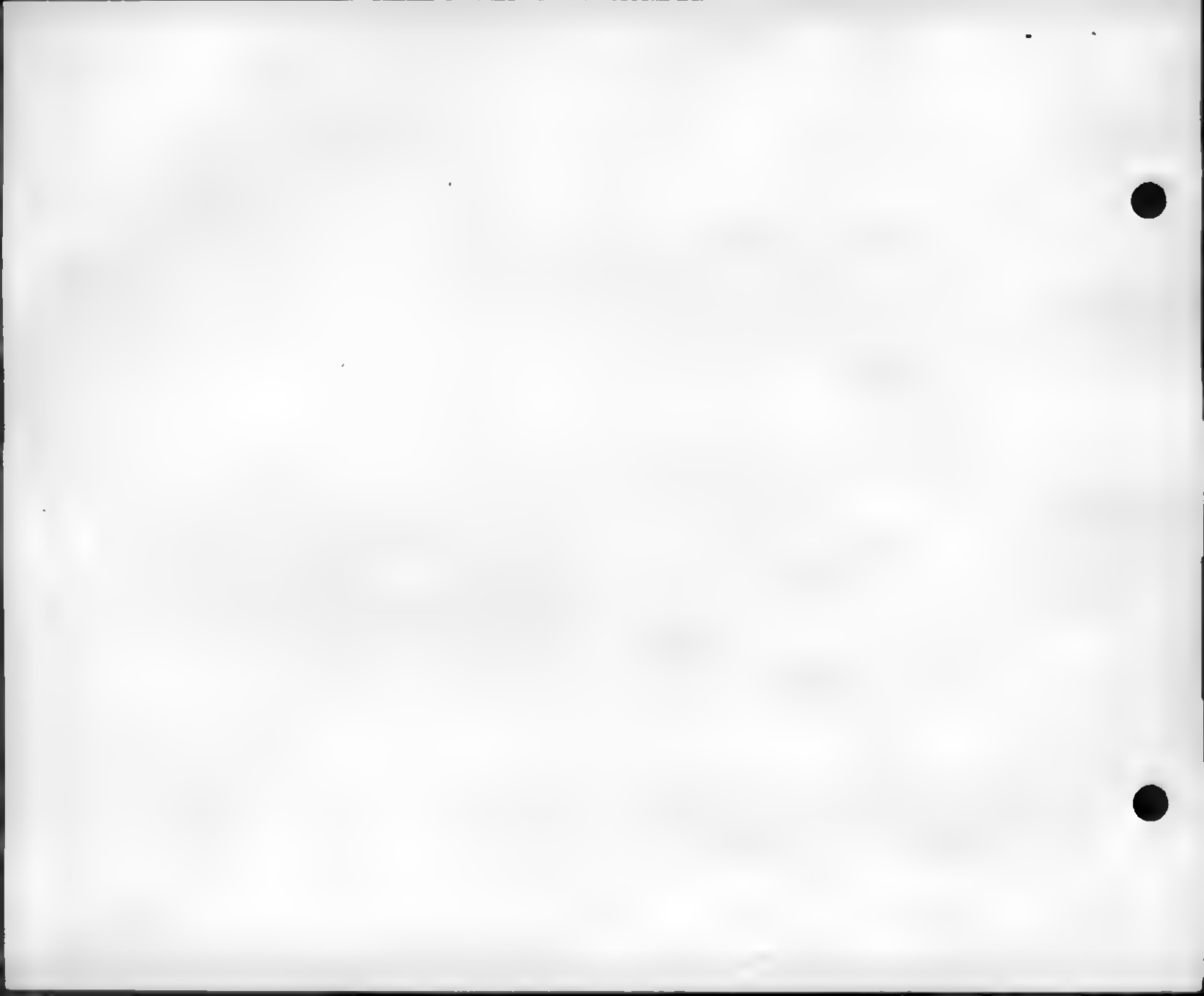
1. M
4364
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

54350

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton c. LENGTH OF STAY IN b 6 weeks d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a. STATE Washington, D.C. b. COUNTY N. E. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) N. E. d. STREET ADDRESS 224 11th St., NW NE e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Annie (no middle name) Johnson		4. DATE OF DEATH Month Day Year 3/31 1968	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/6/1893
9. AGE (In years last birthday) 74 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (County & State, or foreign country) Norfolk, Va.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Lume Hughes	
14. MOTHER'S MAIDEN NAME Mattie Cox		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO 577-68-7121		17. INFORMANT VIVIAN FIELDS Address 224-11th St. NW NE Wash D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF PANCREAS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, 157X DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETIS MELLITUS			INTERVAL BETWEEN ONSET AND DEATH 4 MONTHS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 23 FEB. 1968 to 31 MAR. 1968 . That (I) (we) last saw the deceased alive on 30 MAR. 1968 , and that death occurred at 8:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Walter Goetz		22b. DATE SIGNED 3/31/68	
22c. PHYSICIAN'S NAME (Type) WALTER GOETZ MD		22d. ADDRESS 2309 SHOREFIELD RD WHEATON MD	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 4-4-68	23c. NAME OF CEMETERY OR CREMATORY Harmony Cem	23d. LOCATION (City or town) (County) (State) Landoner Md.
24. FUNERAL DIRECTOR W. W. Chambers Co Inc Wash, D.C.		25a. REC'D BY REGISTRAR APR 4 1968	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



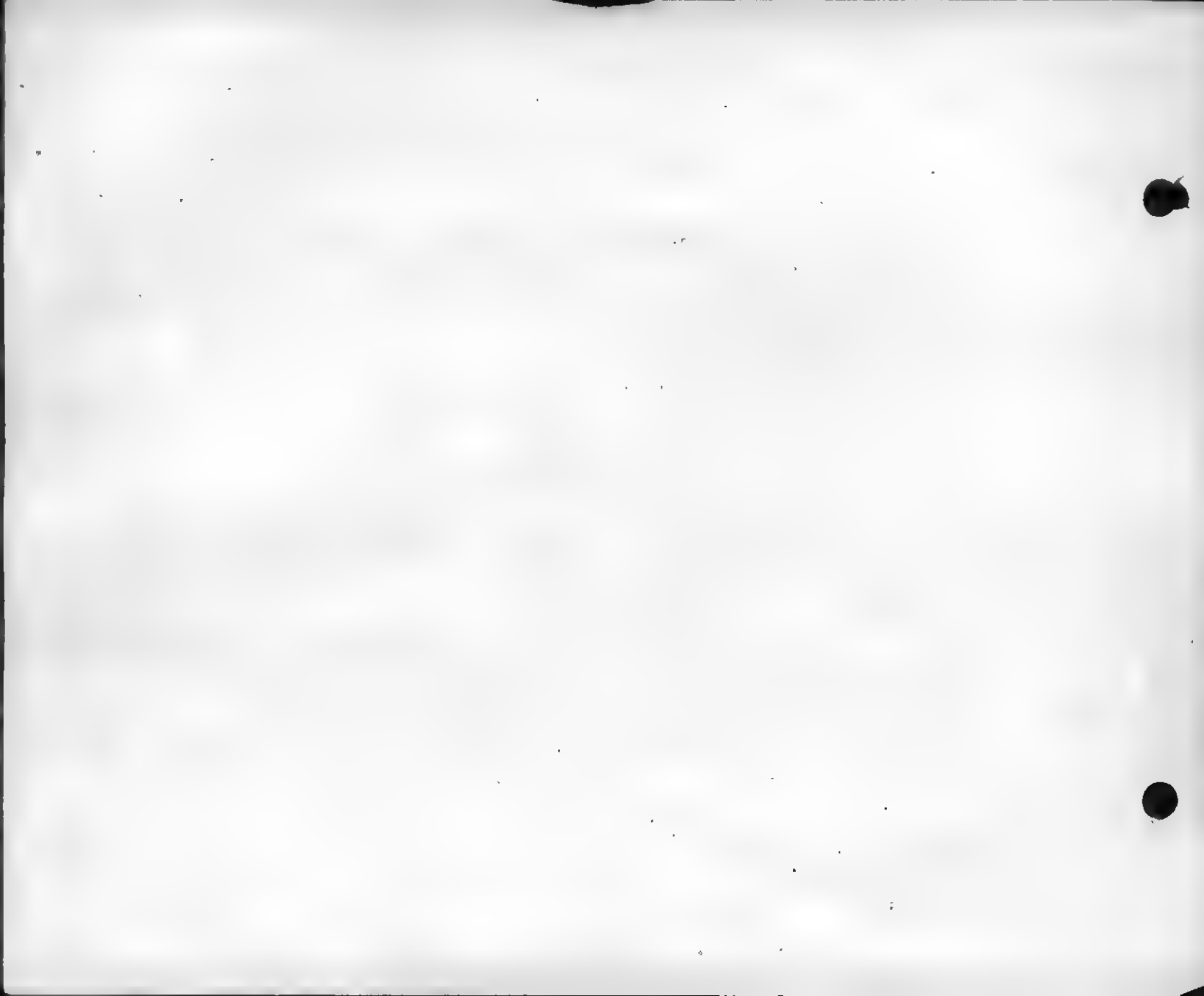
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

Items 18, 22, 39
4-11-68
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) SAMUEL			First Middle Last JOHNSON			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MATED <input type="checkbox"/> 3-2 19 68 12 4 AM	
3 SEX M	4 RACE negro	5 DATE OF BIRTH 11-29-38	6 AGE (In years last birthday) 29 YRS	7 UNDER 1 YEAR MONTHS DAYS	8 UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD 3-2 19 68 12 4 AM	
7a BIRTHPLACE (State or foreign country) Baltimore Md.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give the address) Cross Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Laborer	
13a USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE Md			13b COUNTY Baltimore			13c CITY OR TOWN Baltimore	
14 FATHER'S NAME First Middle Last Samuel Johnson			15 MOTHER'S MAIDEN NAME First Middle Last Edna M. Roberts				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) No			16b SOCIAL SECURITY NO 214-40-6591		17. INFORMANT ADDRESS Edna M. Anderson-3303 Bloomingdale Road		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Severe Bilateral Pneumonitis with right 1888X DUE TO, OR AS A CONSEQUENCE OF Pulmonary Abscess due to Intracranial (b) DUE TO, OR AS A CONSEQUENCE OF trauma (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year 19 HOUR A.M. P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town County State	
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Reap		EXAMINER'S NAME (Type) BELDEN R. REAP		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED March 2, 1968	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 3/6/68		23c NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore Maryland	
24 FUNERAL DIRECTOR Herbert E. Nutter-3035 W. North Ave.				25a REC'D BY REGISTRAR MAR 18 1968		25b REGISTRAR'S SIGNATURE J. Charles Jones	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the original. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

2360 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

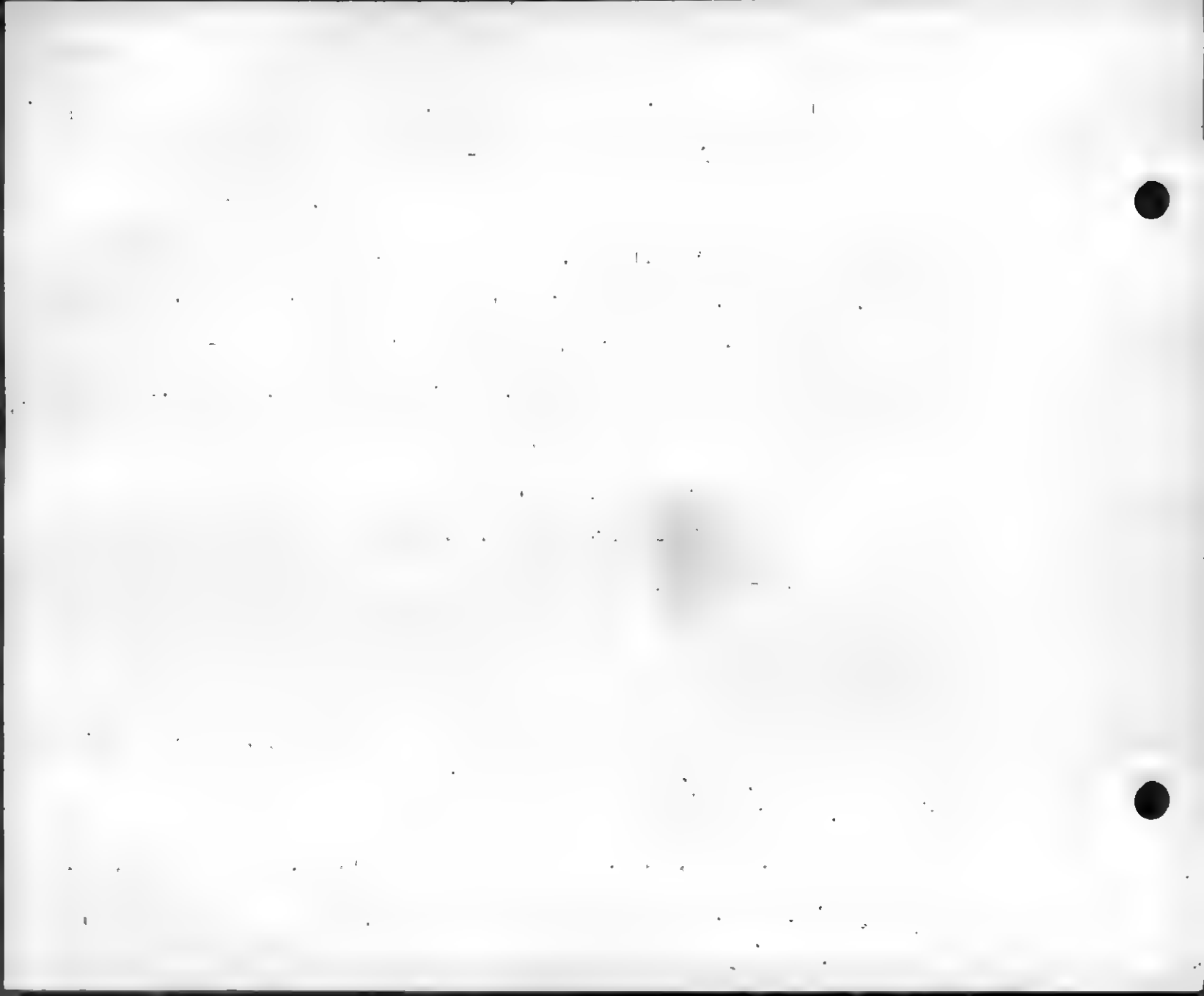
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			Month Day Year			2b HOUR		
SARAH			E. JOHNSON			3 18 68			12:40 AM					
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	F UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD			2d HOUR			
FEMALE	COLORED	1-14-09	59 YRS	MONTHS	DAYS	HOURS	MIN	Month Day Year			12:40 AM			
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md		
MARYLAND			USA						MONTGOMERY					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY					
OLNEY			MONTGOMERY GENERAL			UNEMPLOYED								
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?			13e STREET AND NUMBER		
MD.			MONTGOMERY			DERWOOD			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			19900 ZION RD.		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			First Middle Last			First Middle Last					
JAMES - MATTHEWS			GRACE - EVANS											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS					
No						MEDICAL RECORDS								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Emaciation etiology</u>														
DUE TO, OR AS A CONSEQUENCE OF (b) <u>unknown complicated by</u>														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Chronic Ethylism</u>														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
3221														
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			12:00					
			19 P.M.											
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> OR NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town			County State		
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASSISTANT MEDICAL EXAMINER			DEPUTY MEDICAL EXAMINER			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			Belden R. Read, M.D.									March 18, 1968		
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)					
Burial			Mar. 22, 1968			Brown Chapel			Dayton			Howard Md.		
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REG STR			25b REGISTRAR'S SIGNATURE					
Robert L. Snowden			Rockville, Md.			MAR 21 1968			William C. Yager					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>436</div> <div> <div>435</div> <div>435</div> </div>																	
<div> <div>1</div> <div>2</div> </div>																	
<div> <div>1. DECEASED-NAME (Type or print)</div> <div>First</div> <div>Middle</div> <div>Last</div> <div>2a. DATE OF DEATH</div> <div>2b. HOUR</div> </div>																	
WILLIAM			EDWARD			JOHNSON			<div> <div>Month</div> <div>3</div> </div> <div> <div>Day</div> <div>24</div> </div> <div> <div>Year</div> <div>68</div> </div>		<div> <div>P</div> <div>2:50</div> </div>						
3 SEX			4 RACE			5. DATE OF BIRTH			6 AGE (In years lost birthday)		<div> <div>IF UNDER 1 YEAR</div> <div>MONTHS</div> <div>DAYS</div> </div> <div> <div>IF UNDER 24 HRS</div> <div>HOURS</div> <div>MIN</div> </div>						
MALE			COLORED			7-7-1876			91 YRS								
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH								
MARYLAND			USA						MONTGOMERY Md.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)						12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY						
BROOKEVILLE			19808 ZION RD.						RETIRED		NONE						
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER						
MD.			MONTGOMERY			BROOKEVILLE					19808 ZION RD.						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME														
First			Middle			Last			First			Middle			Last		
JEREMIAH			-			JOHNSON			RACHAEL			-			?		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT						Address					
No						MRS. ZELMA SNOWDEN 19808 ZION RD., BROOKEVILLE											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																	
PART I. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) PULMONARY EDEMA - TERMINAL																	
DUE TO, OR AS A CONSEQUENCE OF																	
(b) CORONARY HEART DISEASE																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c) ARTERIOSCLEROTIC C. V. DISEASE																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																	
PYELONEPHRITIS - HYPERTENSION																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
			HOUR A.M. Month Day Year														
			P.M. 19														
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			City or Town			County			State		
White <input type="checkbox"/> Not white <input type="checkbox"/>						Street or R.F.D. No.											
at work <input type="checkbox"/> at work <input type="checkbox"/>																	
22a. I certify that (1) (this hospital) attended the deceased from APRIL, 1964, to MAR. 24, 1968, that (1) (we) last saw the deceased alive on MARCH 16, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE			22c. DATE SIGNED			22d. ADDRESS											
Donald R. Lewis			MARCH 25, 1968			700 CLOVERLY ST., SILVER SPRING, MD.											
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS			22f. ADDRESS											
DONALD R. LEWIS, M. D.						700 CLOVERLY ST., SILVER SPRING, MD.											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)			(County)			(State)		
BURIAL			3-27-68			MT. Zion			MT. Zion			Montgo, Md.					
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
R. L. Snowden			DATE			MAR 29 1968											



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

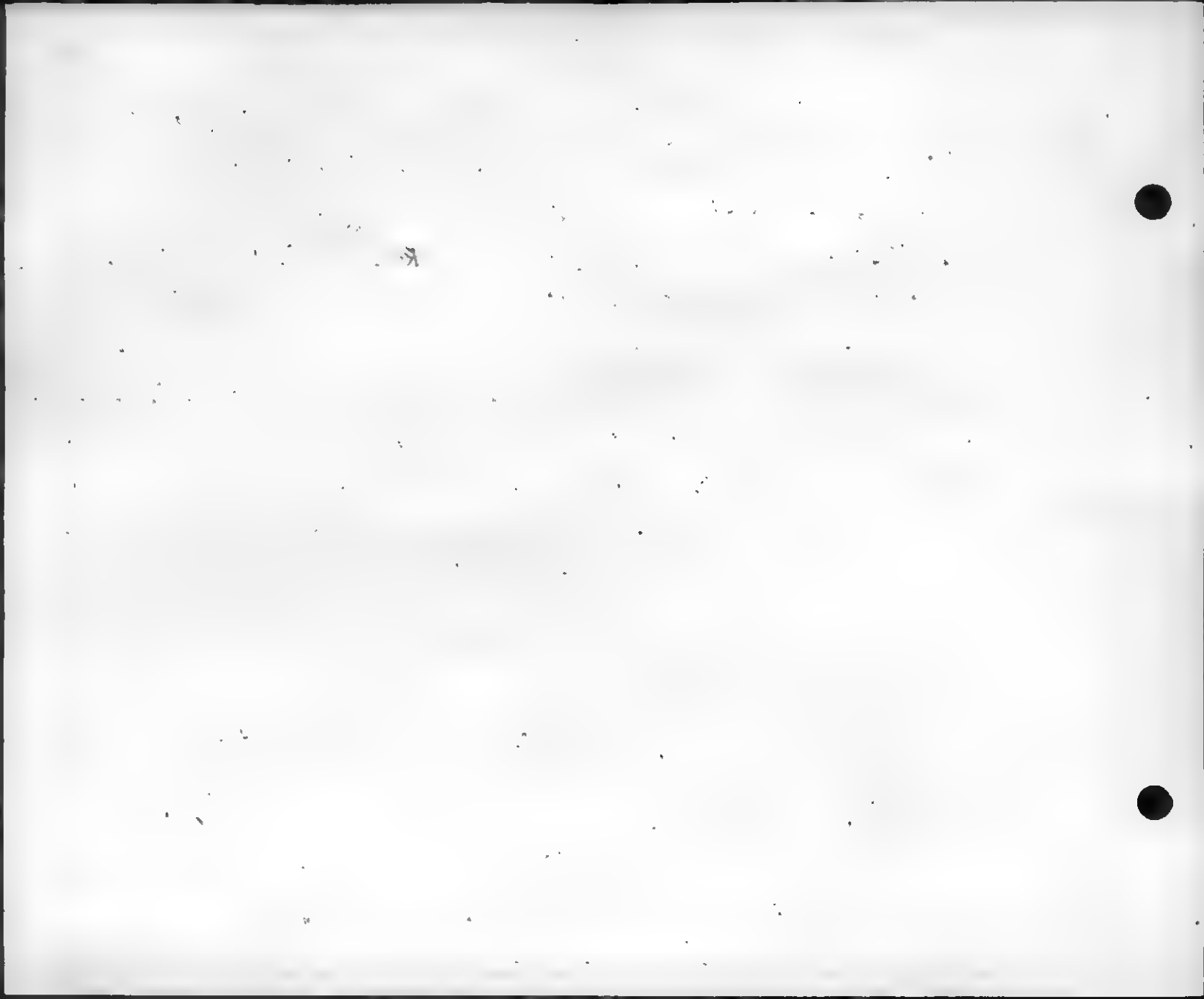
1. DECEASED NAME (Type or Print) JUNE			First JOHNSTON			Last			2a. DATE KNOWN OF DEATH Month 3 Day 12 Year 1968			2b. HOUR 8:46			
3 SEX Female		4 RACE White		5 DATE OF BIRTH 1/17/09		6 AGE (in years last birthday) 59 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN. 0		2c. DATE PRONOUNCED DEAD Month 3 Day 12 Year 1968		2d. HOUR 8:46	
7a. BIRTHPLACE (State or foreign country) Capitol Bridge West Va.				7b. CITIZEN OF WHAT COUNTRY? U. S.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Montgomery Md			
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of work on life, even if retired) Housewife				12b. KIND OF BUSINESS OR INDUSTRY			
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.				13b. COUNTY Montgomery				13c. CITY OR TOWN Silver Sp.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 12209 Charles Road			
14. FATHER'S NAME William Clark Slonaker				15. MOTHER'S MAIDEN NAME Minnie Stanholtz				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO.			
17. INFORMANT Mr. Delbert Johnston				18. ADDRESS 12209 Charles Rd. Sil. Sp., Md.				19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fatty metamorphosis of Liver. Acute. 571.8 DUE TO, OR AS A CONSEQUENCE OF (b) Cirrhosis of Liver. DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 571.0															
19a. DATE OF OPERATION 5/10				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE John B. Bail				M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 3/13/68			
EXAMINER'S NAME (Type)				ASSISTANT MED. EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 3/15/68				23c. NAME OF CEMETERY OR CREMATORY Mount Hebron				23d. LOCATION (City or Town) (County) (State) Winchester Va. 22601			
24. FUNERAL DIRECTOR Harold M. Boyeant, Winchester, Va.				ADDRESS				25a. REC'D BY REGISTRAR MAR 18 1968				25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Lamar</i>		First <i>Lamar</i>		Middle <i>Jones</i>		Last <i>Jones</i>		2a. DATE OF DEATH Month <i>March</i> Day <i>28</i> Year <i>1968</i>		2b. HOUR <i>7:45 AM</i>	
3 SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>August 15, 1905</i>		6. AGE (In years last birthday) <i>62</i> YRS		IF UNDER 1 YEAR MONTHS <i>12</i> DAYS <i>12</i>		IF UNDER 24 HRS. HOURS <i>7</i> MIN <i>45</i>	
7a. BIRTHPLACE (State or foreign country) <i>Alabama, Ala.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.					
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Self-employed</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Station</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>1003 Robin Road</i>			
14. FATHER'S NAME First <i>Lamar</i> Middle <i>Jones</i> Last <i>Jones</i>		15. MOTHER'S MAIDEN NAME First <i>Minnie</i> Middle <i>Monk</i> Last <i>Monk</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>no</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>578-48-0311</i>		17. INFORMANT Address <i>Mrs. John Oliver 1003 Robin Road, S. S. Md.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>COMA - CEREBRAL</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>CEREBRAL METASTASIS</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>UNDIFFERENTIATED CARCINOMA - PRIMARY</i> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>SITE UNKNOWN - CARCINOMA METASTASIS</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>7 MO</i>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>NOV. 22, 1967</i> to <i>MARCH 28, 1968</i> , that (I) (we) last saw the deceased alive on <i>MARCH 28, 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>William Frank, M.D.</i> DEGREE <i>M.D.</i> ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>										22c. DATE SIGNED <i>APR 3, 1968</i>	
22d. PHYSICIAN'S NAME (Type) <i>WILLIAM FRANK, M.D.</i>		22e. ADDRESS <i>1125 ROCKVILLE PIKE, ROCKVILLE</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE <i>3/30/1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Wainmont Cemetery</i>		23d. LOCATION (City or Town) <i>newark</i> (County) <i>New</i> (State) <i>Del.</i>					
24. FUNERAL DIRECTOR <i>James E. Pumphrey, Inc., 9434 La., S.E. Md.</i>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							
DATE <i>APR 3, 1968</i>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1/68

64310

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) FRED JONES			2a DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 3-30-68			2b HOUR 3:15 AM		
3 SEX M	4 RACE NEGRO	5 DATE OF BIRTH 3-15-27	AGE (in years last birthday) 41 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD 30 1968		
7a BIRTHPLACE (State or foreign country) N.C.		7b COUNTRY OF WHAT COUNTRY USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md		
10 CITY OR TOWN OF DEATH Good Hope		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) LABORER		12b KIND OF BUSINESS OR INDUSTRY NONE		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY Monte		13c CITY OR TOWN SILVER SPRING		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Middle Last CHARLES JONES			15 MOTHER'S MAIDEN NAME First Middle Last Estelle Johnson			13e STREET AND NUMBER Rt 2 Good Hope Rd		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17. INFORMANT ADDRESS				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extreme Conflagration DUE TO, OR AS A CONSEQUENCE OF (b) Burns, entire body, incurred in DUE TO, OR AS A CONSEQUENCE OF (c) House fire, origin unknown PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 91 min								
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year 10:30 3-30-68		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Deceased burned in house fire				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f LOCATION Street or RFD No. City or Town County State Rte. 2 Good Hope Rd. S.S. Montgomery Md.				
22a. I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Belden K. Beapad			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED 3/30/1968		
EXAMINER'S NAME (Type) BELDEN K. BEAPAD			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a BURIAL, CREMATION, REMOVAL (Specify) REMOVAL			23b DATE 4-2-68		23c NAME OF CEMETERY OR CREMATORY W. D. Allen Fun. Home		23d LOCATION (City or Town) (County) (State) OXFORD N.C.	
24 FUNERAL DIRECTOR Robert L. Snowden			ADDRESS ROCKVILLE, MARYLAND			25a REC'D BY REG STRAR APR 9 - 1968		
						25b REG STRAR'S SIGNATURE Charles Judge		

1-1-10

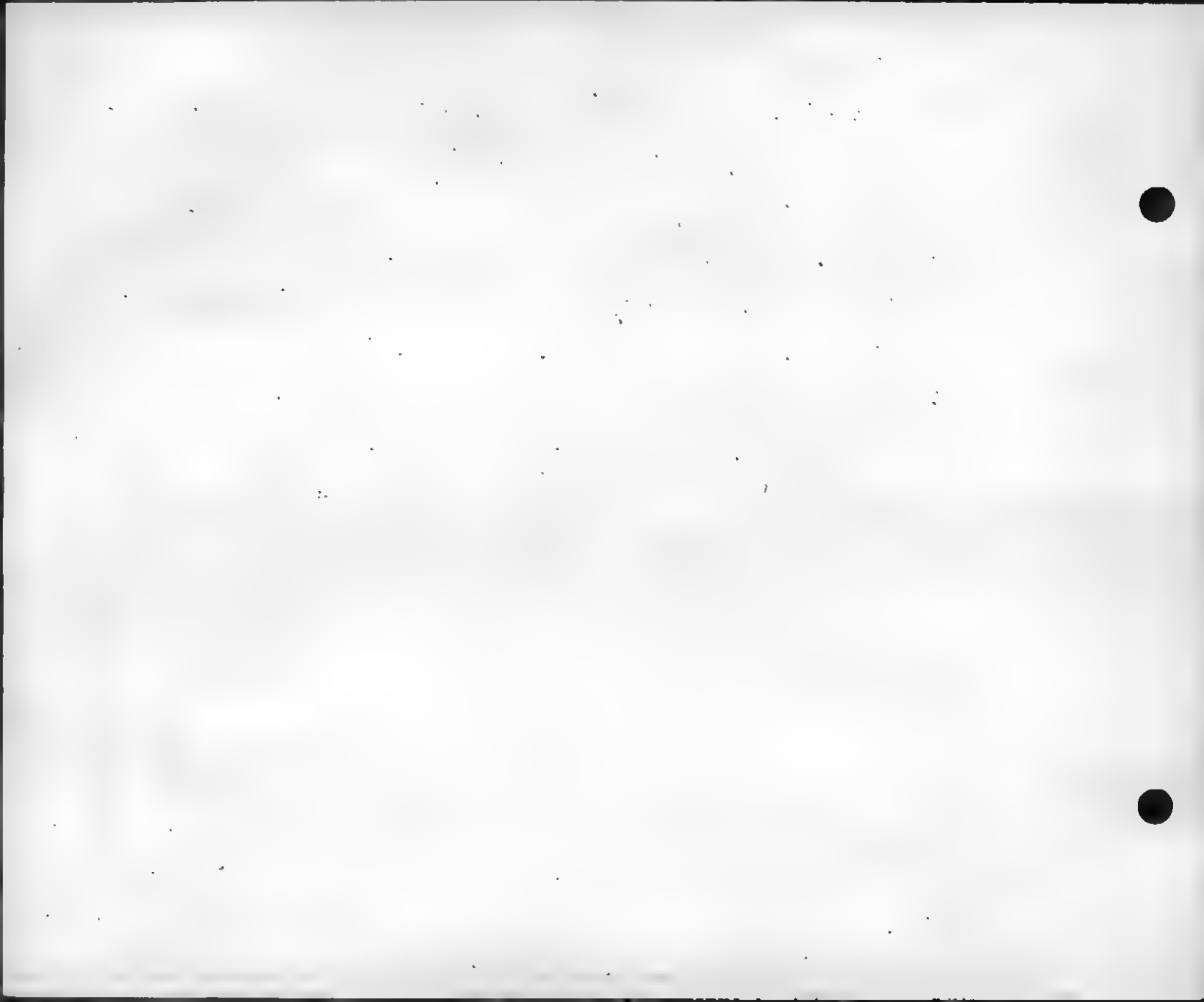
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <i>Lelah Mabel Jones</i>			2a. DATE OF DEATH Month <i>3</i> Day <i>17</i> Year <i>68</i>			2b. HOUR <i>7:35 AM</i>	
3 SEX <i>Female</i>		4 RACE <i>White</i>		5. DATE OF BIRTH <i>6-7-94</i>		6 AGE (In years last birthday) <i>73</i> YRS	
7a BIRTHPLACE (State or foreign country) <i>Indiana</i>		7b CITIZEN OF WHAT COUNTRY? <i>Amer.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md	
10 CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Wash. San. & Hosp</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Asst</i>		12b KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Takoma Park</i>		13d. 145-DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER <i>7138 Carroll Ave.</i>		14 FATHER'S NAME First <i>Edward</i> Middle <i>Sanders</i> Last <i>Rose</i>		15. MOTHER'S MAIDEN NAME First <i>Rose</i> Middle <i>Gerkin</i> Last <i>Gerkin</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO.		17. INFORMANT <i>Hosp. admission record</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> <i>4-109</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>arterio-sclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>March 14, 1968</i> , to <i>Mar. 17, 1968</i> , that (I) (we) last saw the deceased alive on <i>March 16, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <i>A. B. Little M.D.</i>		22c. DATE SIGNED <i>Mar. 17, 1968</i>		22d. PHYSICIAN'S NAME (Type) <i>A. B. LITTLE M.D.</i>		22e ADDRESS <i>6911-5th St NW, Wash DC 20012</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>Mar 22/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Not stated</i>		23d. LOCATION (City or Town) (County) (State) <i>Chesapeake Indiana</i>	
24. FUNERAL DIRECTOR <i>Charles Judge</i>		ADDRESS <i>254 Carroll St NW</i>		25a. REC'D BY REGISTRAR <i>20 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



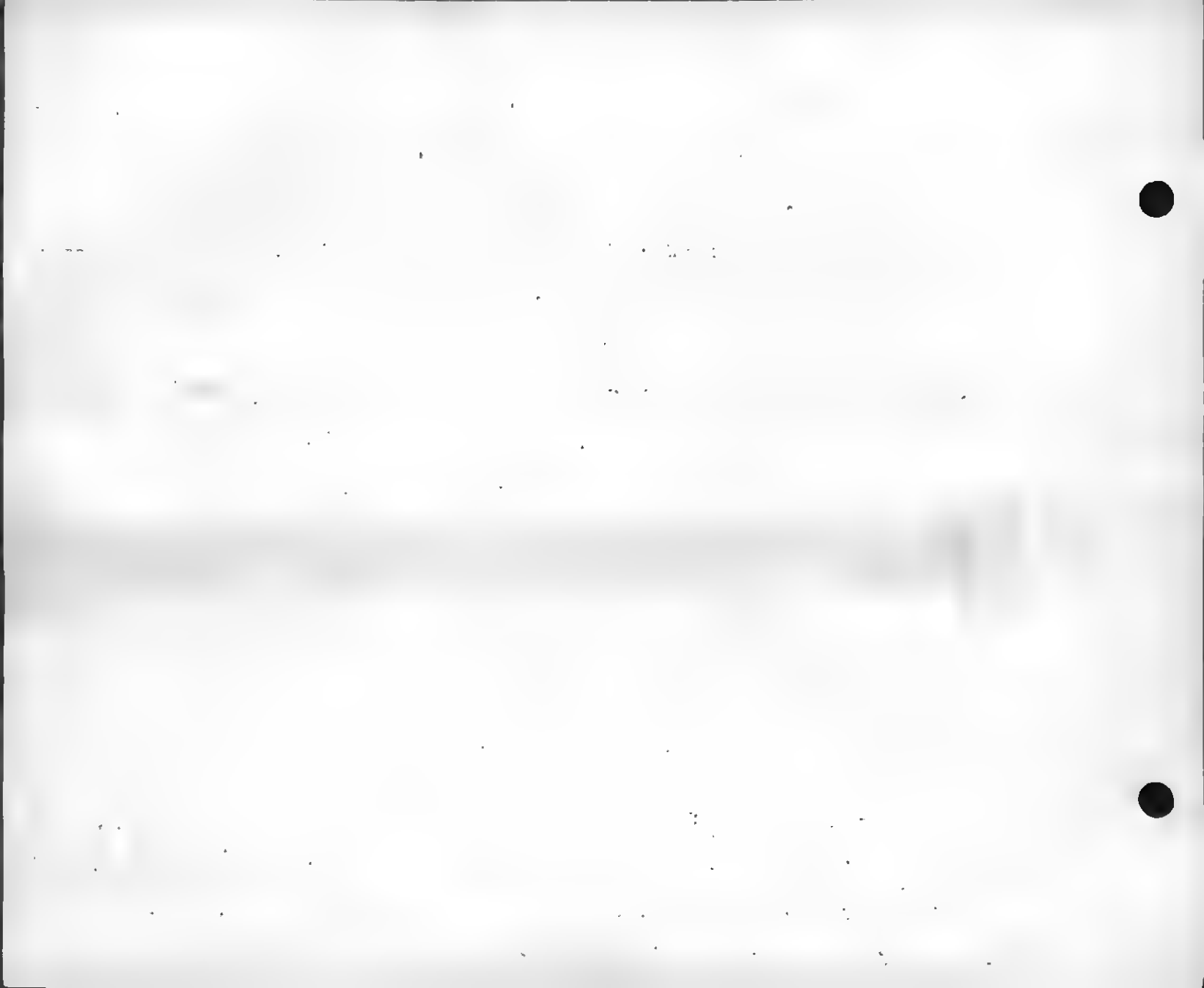
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VR A15 (4)
30M REV 1/68

1. DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
Bertha				D		Kaiser	Month <u>March</u> Day <u>7</u> Year <u>1968</u>			8:15 AM	
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Female		White		June 18, 1886			81 YRS.		MONTHS		DAYS
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Oxen Hill, Md.		US				Montgomery, Md					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring, Md.			Colonial Villa Nursing Home			Housewife			----		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Wash. D.C.						D.C.				10 9th St. S.E.	
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
John					Dement	Frances					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17 INFORMANT Address					
no				579-60-1232		Colonial Villa 12325 New Hampshire Ave. Silver Spring, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u>											
1109 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) <u>Osteogenic Sarcoma - tumor</u>											8-12 months
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
196.9											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			P.M. 19								
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21b. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No			City or Town		
									County		
									State		
22a. I certify that (I) (this hospital) attended the deceased from <u>2/26</u> , 19 <u>68</u> , to <u>3/7</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3/6</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>R.H. Sandstrom</u>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <u>3/7/68</u>		
22d. PHYSICIAN'S NAME (Type) <u>R.H. Sandstrom</u>						22e. ADDRESS <u>7701 Carroll Ave Takoma Park, Md</u>					
23a. BURIAL PERMIT, REMOVAL (Specify)			23b. DATE <u>3/11/68</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>			23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>		
24 FUNERAL DIRECTOR ADDRESS <u>JAMES T. RYAN, INC 3111A AVE, S.E. DC 3</u>						25a. REC'D BY REGISTRAR DATE <u>MAR 8 1968</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

MEDICAL CERTIFICATE



CERTIFICATE OF DEATH

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1. DECEASED NAME (Type or print) <i>Ellen Kane</i>		First Middle Last		2a. DATE OF DEATH Month Day Year <i>March 14 1968</i>		2b. HOUR <i>1:40 A.M.</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>August 23, 1883</i>		6. AGE (in years lost birthday) <i>84</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Ireland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md	
10. CITY OR TOWN OF DEATH <i>Silver Springs</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Fairland Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>D.C.</i>		13b. COUNTY <i>C</i>		13c. CITY OR TOWN <i>WASH.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>3517 O ST. N.W.</i>		14. FATHER'S NAME First Middle Last <i>PATRICK SARGFIELD</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>ANN FEENEY</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <i>No</i>		16b. SOCIAL SECURITY NO		17. INFORMANT <i>HUSBAND - FRANK KANE</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Anemia</i> <i>2009</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Melancholic Urinary Bleeding</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>urinary tract polyps</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>2</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>3/30, 1967</i> , to <i>3/14/68</i> , that (I) (we) last saw the deceased alive on <i>3/10/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Boris Rabkin</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>3/14/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>BORIS RABKIN MD</i>				22e. ADDRESS <i>1019 Union Road East</i>			
23a. BURIAL CREMATION REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>3-16-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>GATE OF HEAVEN CEM.</i>		23d. LOCATION (City or Town) (County) (State) <i>W/HEATON MD.</i>	
24. FUNERAL DIRECTOR <i>James E. D'Silva - Wash. D.C.</i>				25a. REC'D BY REGISTRAR DATE <i>MAR 26 1968</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



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5374
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04361

1. DECEASED-NAME (Type or print) William Aloysius Kane			2a. DATE OF DEATH Month March Day 5 Year 1968		2b. HOUR 10:50 AM
3 SEX Male	4 RACE Caucasian	5. DATE OF BIRTH July 5, 1892		6 AGE (In years last birthday) 75 YRS.	
7a. BIRTHPLACE (State or foreign country) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 COUNTY OF DEATH Montgomery			10. CITY OR TOWN OF DEATH Bethesda		
11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4401 East West Hwy.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired		12b. KIND OF BUSINESS OR INDUSTRY N/A
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before address) STATE Maryland		13b. CITY OR TOWN Montgomery	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 4401 East West Hwy.	
14. FATHER'S NAME First John Middle J. Last Kane			15. MOTHER'S MAIDEN NAME First Ellen Middle C. Last Hegarty		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) No		16b. SOCIAL SECURITY NO 579-54-8910		17 INFORMANT Address Mae A. Kane, Wife, Same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 100% X Hemia, terminal DUE TO, OR AS A CONSEQUENCE OF (b) Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of Prostate					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days 2 1/2 years 3 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 175% Bronchitis, chronic					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (the hospital) attended the deceased from June , 1961, to March 5 , 1968, that (I) (we) last saw the deceased alive on March 4 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John F. Brennan Jr. MD		DEGREE MD		22c. DATE SIGNED March 5, 1968	
22d. PHYSICIAN'S NAME (Type) John F. Brennan		22e. ADDRESS 1034 PERRY ST. N.E. WASH. DC 20017			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/8/68		23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery	
23d. LOCATION (City or Town) Forest Glen, Maryland					
24. FUNERAL DIRECTOR Joseph Gawler's Sons, 5130 Wis., Wash., D.C.		25a. REC'D BY REGISTRAR DATE MAR 8 1968		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION



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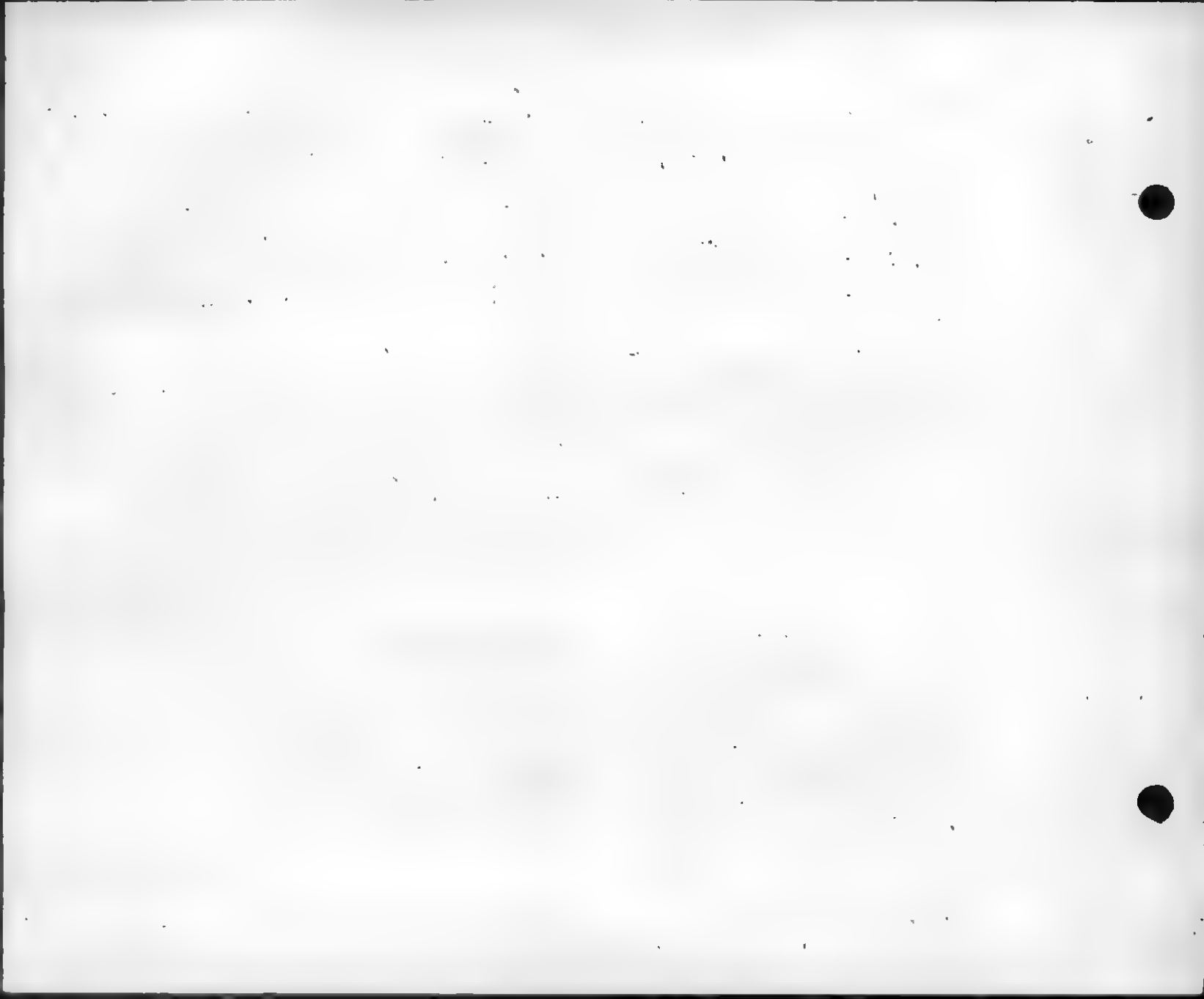
1M

237

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

54362

1 DECEASED-NAME (Type or print) <u>First</u> <u>Face</u> <u>Middle</u> <u>A.</u> <u>Last</u> <u>Seese</u>		2a. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>1968</u>		2b. HOUR <u>8 P.</u> MIN <u>M</u>
3. SEX <u>female</u>	4. RACE <u>White</u>	5. DATE OF BIRTH <u>Jan. 24/1927</u>		6. AGE (In years lost birthday) <u>41</u> YRS
7a. BIRTHPLACE (State or foreign country) <u>York Co. Penn.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
9. COUNTY OF DEATH <u>Montgomery</u> Md				
10. CITY OR TOWN OF DEATH <u>Rockville, Md</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Potomac Valley Nursing Home</u>		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) <u>NSA</u>
12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md.</u>		13b. COUNTY <u>Mont.</u>	13c. CITY OR TOWN <u>Wash. D.C.</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First <u>TRUMAN</u> Middle <u>S</u> Last <u>SHULTZ</u>		15. MOTHER'S MAIDEN NAME First <u>UNKNOWN</u> Middle <u></u> Last <u></u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT <u>THOMAS KEESEY</u> Address <u>936 NORTH BRAR PA YORK PA</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>153.8</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma, colon</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>153.8</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> <u>3 months</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Cerebral Thrombosis; Left Hemiplegia</u>				
19a. DATE OF OPERATION <u>7-1-1968</u>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Colostomy (Ca - Colon)</u>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.	21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 3, 1968</u> to <u>March 13, 1968</u> , that (I) (we) last saw the deceased alive on <u>March 13, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <u>C.R. Gruyer, M.D.</u>		DEGREE <u></u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <u>3/13/68</u>	
22d. PHYSICIAN'S NAME (Type) <u>C. R. GRUYER</u>		22e. ADDRESS <u>915 19th St NW W. DC</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>3/16/68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST MARYS</u>	23d. LOCATION (City or Town) <u>YORK</u> County <u>YORK</u> State <u>Pa.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		ADDRESS <u>1331 Rock Pike Rockville, Md.</u>	25a. REC'D BY REGISTRAR <u>MAR 18 1968</u>	25b. REGISTRAR'S SIGNATURE <u>J. J. Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print) <u>Keifel, Katherine J.</u>						2a. DATE OF DEATH 3 Month 11 Day 68 Year			2b. HOUR 10:2 P.M.			
3. SEX F		4. RACE W		5. DATE OF BIRTH 11/13/1876			6. AGE (in years last birthday) 91 YRS		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Conn.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md						
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Sales clerk			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY Mont.		13c. CITY OR TOWN Langley Pk		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 8106 New Hampshire Ave			
14. FATHER'S NAME First Middle Last Timothy Burns				15. MOTHER'S MAIDEN NAME First Middle Last Kate Houlihan								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)				16b. SOCIAL SECURITY NO 041-22-9224		17. INFORMANT MRS IRENE KOLLAR 1700 Overbrook S.E. Md.						
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CORONARY ATHEROSCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MONTH 10 YRS.		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>TRACTION L4 VERTEBRA</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from <u>OCT 3/8</u> , 19 <u>67</u> to <u>MARCH 11</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3/8</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>L.B. Snow</u> M.D. DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/11/68				
22d. PHYSICIAN'S NAME (Type) L. B. SNOW.						22e. ADDRESS 7950 N.H. Ave., Hyattsville, Md. 1900 Overbrook Dr. Hillandale, S.E. Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Mar. 14, 1968		23c. NAME OF CEMETERY OR CREMATORY St. Benedict		23d. LOCATION (City or Town) (County) (State) Hartford, Conn.						
24. FUNERAL DIRECTOR W. H. Attanelli						ADDRESS 360 3rd St N.W. Wash. 20010		25a. REC'D BY REGISTRAR DATE MAR 13 1968		25b. REGISTRAR'S SIGNATURE Charles Young		

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Norman Edward Kelly			2a. DATE OF DEATH Month March Day 29 Year 1968			2b. HOUR 9:40 P M	
3 SEX Male		4. RACE Negro		5. DATE OF BIRTH 9/22/96		6 AGE (In years last birthday) 71 YRS	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10 CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Montgomery General Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clergyman		12b. KIND OF BUSINESS OR INDUSTRY Religious	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Spencerville		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
13e. STREET AND NUMBER Batson Road		14. FATHER'S NAME First Middle Last Nelson Kelly		15. MOTHER'S MAIDEN NAME First Middle Last Selena			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) yes (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT Address records, Montgomery General Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Vascular accident (Thrombosis) DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 days 1 month
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 2-27-1968 to 3-29-1968 , that (I) (we) last saw the deceased alive on 3-27-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. Seen by Consultant neurologist							
22b. SIGNATURE John R. Spencer		22c. DATE SIGNED 3-29-68		22d. PHYSICIAN'S NAME (Type) John R. Spencer, M. D.			
22e. ADDRESS Burtonsville, Md.							
23a. BURIAL (CREMATION, REMOVAL) Burial		23b. DATE 4-3-68		23c. NAME OF CEMETERY OR CREMATORY Round Oak Church, Spencerville, Montg, Md		23d. LOCATION (City or Town) (County) (State) Spencerville, Montg, Md	
24. FUNERAL DIRECTOR George R. Snowden		24a. ADDRESS Rockville		25a. REC'D BY REGISTRAR APR 2 - 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



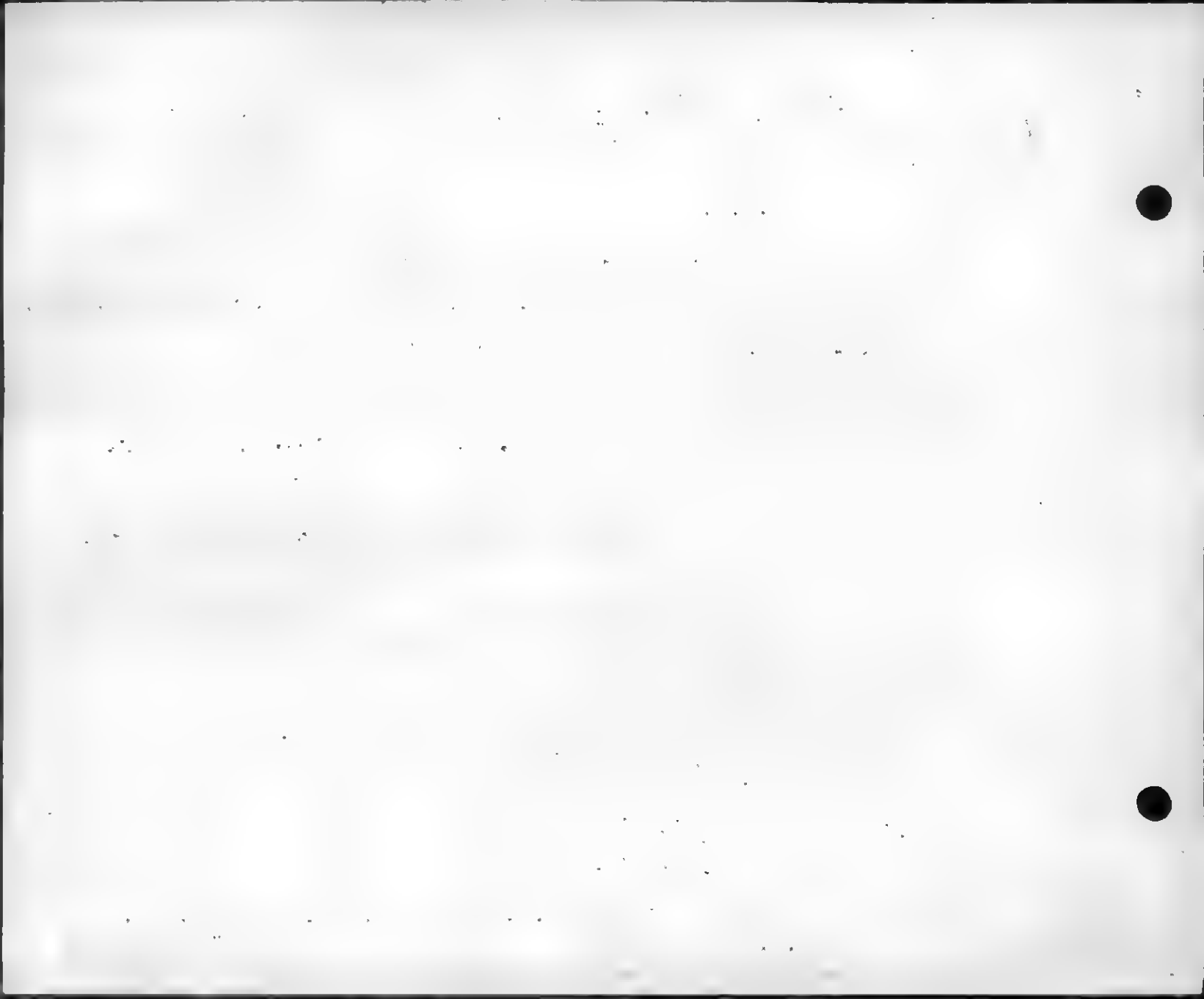
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

2375
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Ellen Sidney Kent			2a. DATE OF DEATH Month March Day 29 Year 1968			2b. HOUR 6 PM			
3 SEX female		4. RACE white		5. DATE OF BIRTH 7/26/78		6 AGE (In years last birthday) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md			
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll Hall Sanitarium		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) Retired teacher		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Wash. D.C.		13c. CITY OR TOWN Wash. D.C.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1629 Columbia Rd. N.W.	
14. FATHER'S NAME First Middle Last Jonathan Yates Kent				15. MOTHER'S MAIDEN NAME First Middle Last Ellen Victoria Belt					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Joseph Stoutenburgh				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis & Hypertension							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 days 5 years years?		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from March 11, 1968 , to March 29, 1968 , that (I) (we) last saw the deceased alive on March 28, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Neil P. Campbell		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 3/29/68			
22d. PHYSICIAN'S NAME (Type) Neil P. Campbell		22e. ADDRESS 1629 Col. Rd.							
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 4/1/68		23c. NAME OF CEMETERY OR CREMATORY All Saints Church Cem.		23d. LOCATION (City or Town) (County) (State) Sunderland, Md.			
24. FUNERAL DIRECTOR The S.H. Hines Company Washington, D.C.				25a. REC'D BY REGISTRAR DATE APR 1 - 1968		25b. REGISTRAR'S SIGNATURE Charles Jones			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

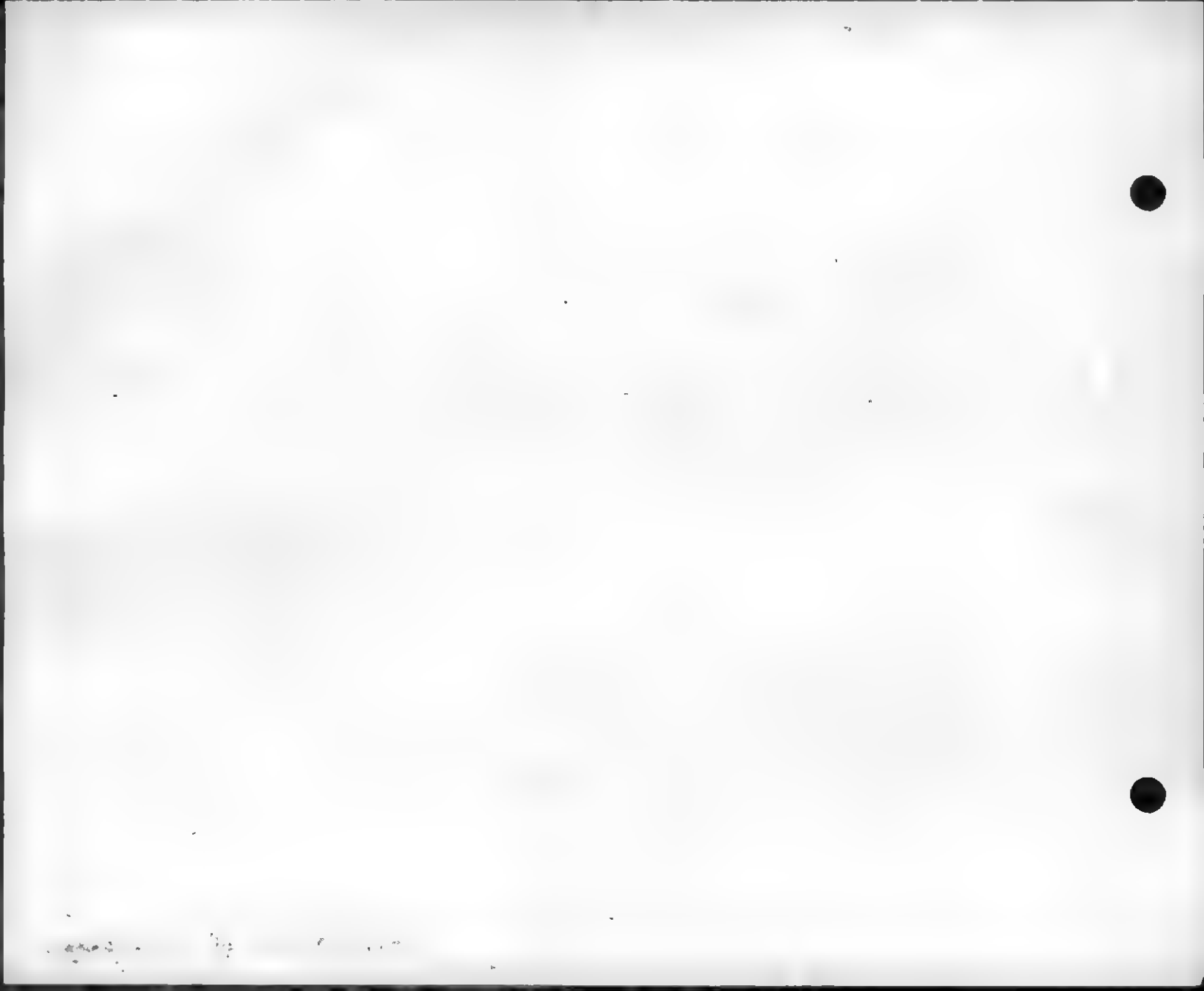
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA 15-1
304 REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

4364

1. DECEASED NAME (Type or print) Pauline Isabel Kimm			First Middle Last			2a. DATE OF DEATH Month 3 Day 2 Year 1968			2b. HOUR 1:1 PM		
3. SEX Female			4. RACE White			5. DATE OF BIRTH 6/2/1891			6. AGE (In years lost birthday) 76 YRS.		
7a. BIRTHPLACE (State or foreign country) Dash., DC			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Beltsville, Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) University Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Stroke			12b. KIND OF BUSINESS OR INDUSTRY Own Store		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Prin			13b. COUNTY Prin			13c. CITY OR TOWN Prin			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 2127 19th St.			14. FATHER'S NAME First Middle Last William Erskine			15. MOTHER'S MAIDEN NAME First Middle Last Annie Frederick					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 78-46-6242			17. INFORMANT Mr. James Snelson			Address: 711 Conant Street Silver Spring, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction 42 X X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Chronic Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardiovascular Disease PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arteriosclerotic Cardiovascular Disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hours	
19a. DATE OF OPERATION 1968			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Acute Myocardial Infarction			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 6-16-1968 to 3-25-1968 , that (I) (we) last saw the deceased alive on 3-25-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John C. Carter, M.D.									22c. DATE SIGNED 3-25-68		
22d. PHYSICIAN'S NAME (Type) John C. Carter, M.D.									22e. ADDRESS 1919 Seminary Rd., Silver Spring, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE March 28, 1968			23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery			23d. LOCATION (City or Town) (County) (State) Prince George County, Md.		
24. FUNERAL DIRECTOR C. Glen Carter						ADDRESS Georgia Ave			25a. RECEIVED BY REGISTRAR 1968		
25b. REGISTRAR'S SIGNATURE James E. Pumphrey, Inc. Silver Spring, Md.						DATE MAR 28 1968			25c. REGISTRAR'S SIGNATURE James E. Pumphrey, Inc.		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR P			
Gabriel			D King			March 7 1968			9:30 AM			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. HOURS MIN	
Male		White		3/19/91			78					
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland			U.S.A.				Montgomery Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during usual of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Olney			Montgomery General Hosp.			unknown						
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland			Montgomery		Gaithersburg		YES		5 Montgomery Avenue			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last									
Elias D. King			Gertrude Lawson									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address							
no			218-20-0042		records: Montgomery Gen. Hosp., Olney, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Apoplexia, Thrombotic</u>										6 days		
4129 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Systemic sclerosis cardiovascular disease</u>										15 yrs		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
422												
9a. DATE OF OPERATION			9b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>3/12</u> , 19 <u>68</u> , to <u>3/12</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3/2</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED			
<u>A. Dement Bonifant</u>									3/8/68			
22d. PHYSICIAN'S NAME (Type) A. Dement Bonifant, M.D.						22e. ADDRESS Sandy Spring, Md.						
23a. BURIAL, CREMATION, REBURN (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			3-9-68		Mt Olivet			Frederick Md				
24. FUNERAL DIRECTOR Ernest C. Gartner ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
<u>Ernest C. Gartner</u> Gaithersburg, Md.						DATE MAR 12 1968		<u>Charles J. Judd</u>				



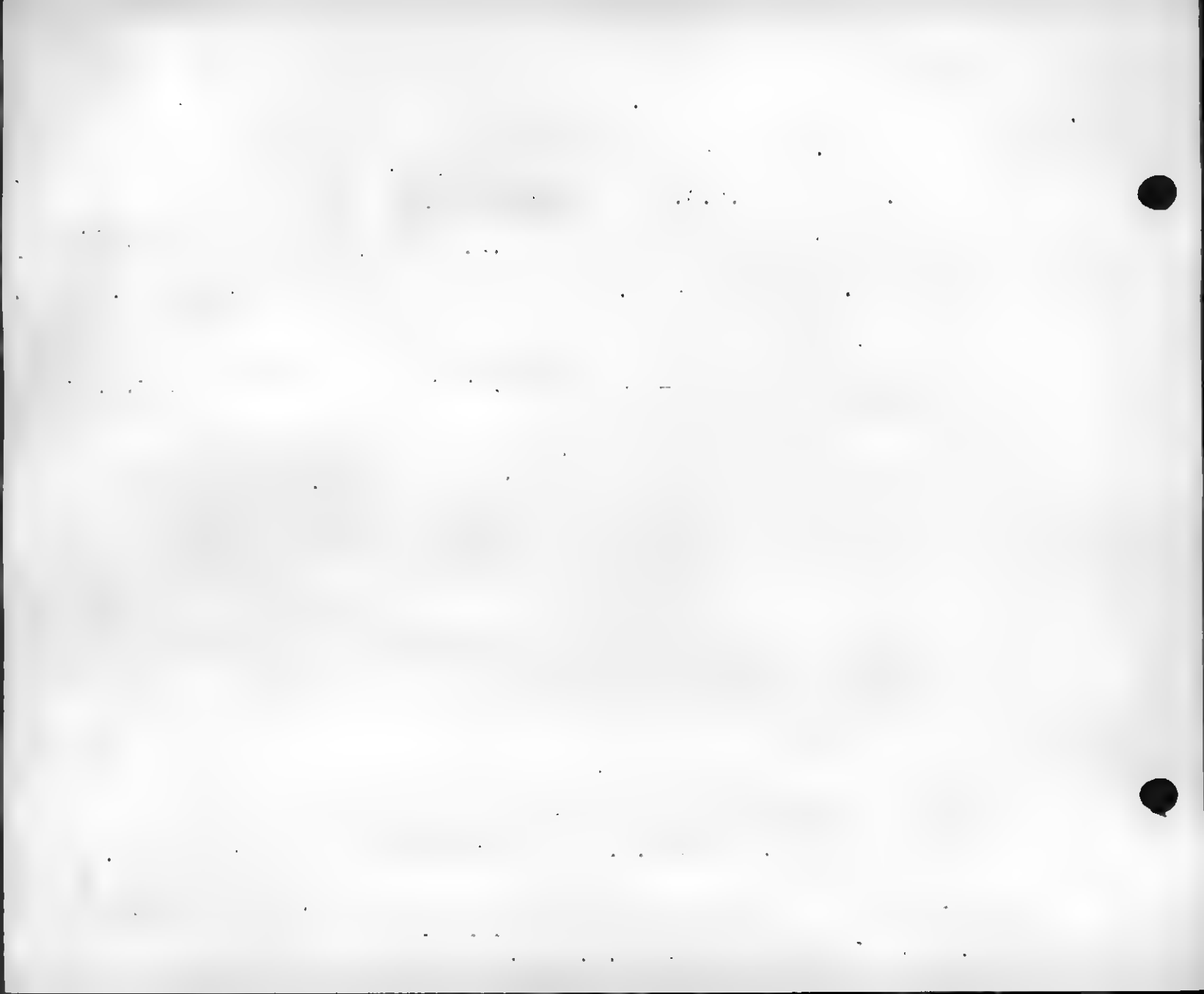
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED NAME (Type or Print) Mabel			First O. Middle Kipfer Last			2a. DATE KNOWN OF DEATH ESTIMATED 3-9 19 68			2b. HOUR M						
3. SEX Fe	4. RACE Cauc.	5. DATE OF BIRTH 4-12-99	6. AGE (in years last birthday) 68 YRS	F UNDER 1 YEAR MONTHS 0 DAYS 0		F UNDER 24 HRS HOURS 0 MIN 0		2c. DATE PRONOUNCED DEAD May 3 Day 19 68			2d. HOUR 9:35				
7a. BIRTHPLACE (State or foreign country) Ill.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NO			9. COUNTY OF DEATH Montgomery			10. CITY OR TOWN OF DEATH Silver Spring			
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Randolph Hills N.H.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Sales Clerk			12b. KIND OF BUSINESS OR INDUSTRY Woodward & Lothrop Dept.			13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY Montg.			
13c. CITY OR TOWN Rockville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 12612 Turkey Br. Pkway.			14. FATHER'S NAME First Otto Middle Wolske Last Ida			15. MOTHER'S MAIDEN NAME First Ida Middle Blagg Last Blagg			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no			16b. SOCIAL SECURITY NO 579-48-4037			16c. INFORMANT Charles J. Kipfer			16d. ADDRESS 12612 Turkey Br. Pkway, S.S., Md.			16e. W. Pumphrey Funeral Home, S.S., Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized Carcinomatosis secondary DUE TO, OR AS A CONSEQUENCE OF to Adenocarcinoma of Cervix. Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 171X												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M. 19			
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No 12612 City or Town Rockville County Montgomery State Md.						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 3-9-68	
ACTUAL SIGNATURE Belden R. Reap			EXAMINER'S NAME (Type) Belden R. Reap, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (City or county) Wheaton, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Interment			23b. DATE March 12, 1968			23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery			23d. LOCATION (City or Town) (County) (State) Rockville, Maryland			23e. REC'D BY REGISTRAR MAK 14 1968			
23f. FUNERAL DIRECTOR C. Glen Carter			23g. ADDRESS 8434 Georgia Avenue, S.S., Md.			23h. REGISTRAR'S SIGNATURE John J. [Signature]			23i. W. Pumphrey Funeral Home, S.S., Md.			23j. DATE MAK 14 1968			

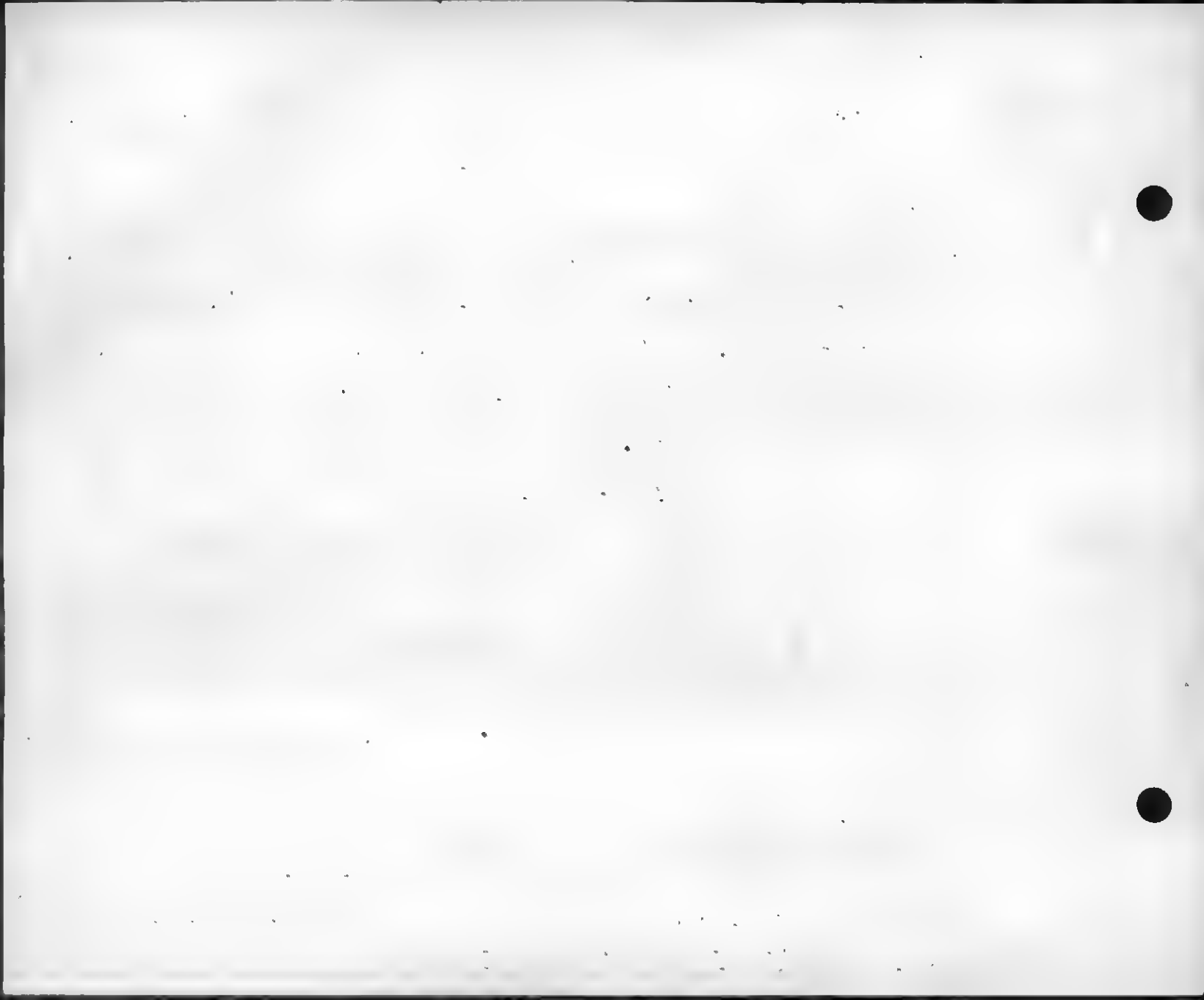


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <i>Meta</i>			First Middle Last			2a. DATE OF DEATH Month <i>March</i> Day <i>14</i> Year <i>1968</i>			2b. HOUR <i>7:00 PM</i>		
3 SEX <i>Female</i>			4. RACE <i>White</i>			5. DATE OF BIRTH <i>Dec. 16, 1891</i>			6. AGE (In years last birthday) <i>76</i> YRS		
7a. BIRTHPLACE (State or foreign country) <i>Latvia</i>			7b. CITIZEN OF WHAT COUNTRY? <i>Latvia</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i> Md		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MD.</i>			13b. COUNTY <i>Montgomery</i>			13c. CITY OR TOWN <i>Garrett Pk.</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last <i>Peter S. Darks</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Analisa Reonis</i>			13e. STREET AND NUMBER <i>11, 115 Rokeby Avenue</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. <i>None</i>			17. INFORMANT <i>Mr. Ernest Kirssteins</i>			Address <i>11115 Rokeby Ave</i>		
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> <i>4124</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) <i>Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 hrs</i> <i>Unknown</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21a. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct</i> , 19 <i>51</i> , to <i>March 19</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>March 19</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>George Sharpe</i>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>March 15, 1968</i>		
22d. PHYSICIAN'S NAME (Type) <i>George Sharpe</i>						22e. ADDRESS <i>10400 Conn. Ave.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Reinterment</i>			23b. DATE <i>March 19, 1968</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Washington, D. C.</i>		
24. FUNERAL DIRECTOR <i>Clark E. Pumphrey, Inc.</i>						ADDRESS <i>508 84th St. Silver Spring, Md.</i>			25a. RECEIVED BY REGISTRAR DATE <i>MAR 19 1968</i>		
						25b. REGISTRAR'S SIGNATURE <i>John J. Jones</i>					



CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <u>Rachel</u>		First Middle Last		2a. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>1968</u>			2b. HOUR <u>1:45 PM</u>		
3. SEX <u>F</u>		4. RACE <u>W</u>		5. DATE OF BIRTH <u>15 Sept '78</u>		6. AGE (In years last birthday) <u>90</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <u>Russia</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md			
10. CITY OR TOWN OF DEATH <u>Cherry Chase</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Cherry Chase</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <u>MD</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Cherry Chase</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>2717-Danvers Rd.</u>	
14. FATHER'S NAME First Middle Last <u>Angel</u> <u>Shapiro</u>		15. MOTHER'S MAIDEN NAME First Middle Last <u>Edith</u> <u>Rebeca</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>no</u>		16b. SOCIAL SECURITY NO <u>no</u>		17. INFORMANT <u>Betty Sachs - daughter - same</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>cerebral thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>degeneration</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u> <u>5 weeks</u> <u>20 yrs</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>stroke</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. BUTTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u>60</u> to <u>5 March</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>5 March</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>M. H. Hirsch, M.D.</u>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>5 March 68</u>			
22d. PHYSICIAN'S NAME (Type) <u>Milton G. Gussak, M.D.</u>		22e. ADDRESS <u>1100-22nd St. N.W. Wash DC 20037</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>2/7/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Adas Israel</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>			
24. FUNERAL DIRECTOR <u>BERNARD DANZANSKY & SONS - WASH. DC</u>		ADDRESS		25a. REC'D BY REGISTRAR DATE <u>MAR 11 1968</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Jones</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

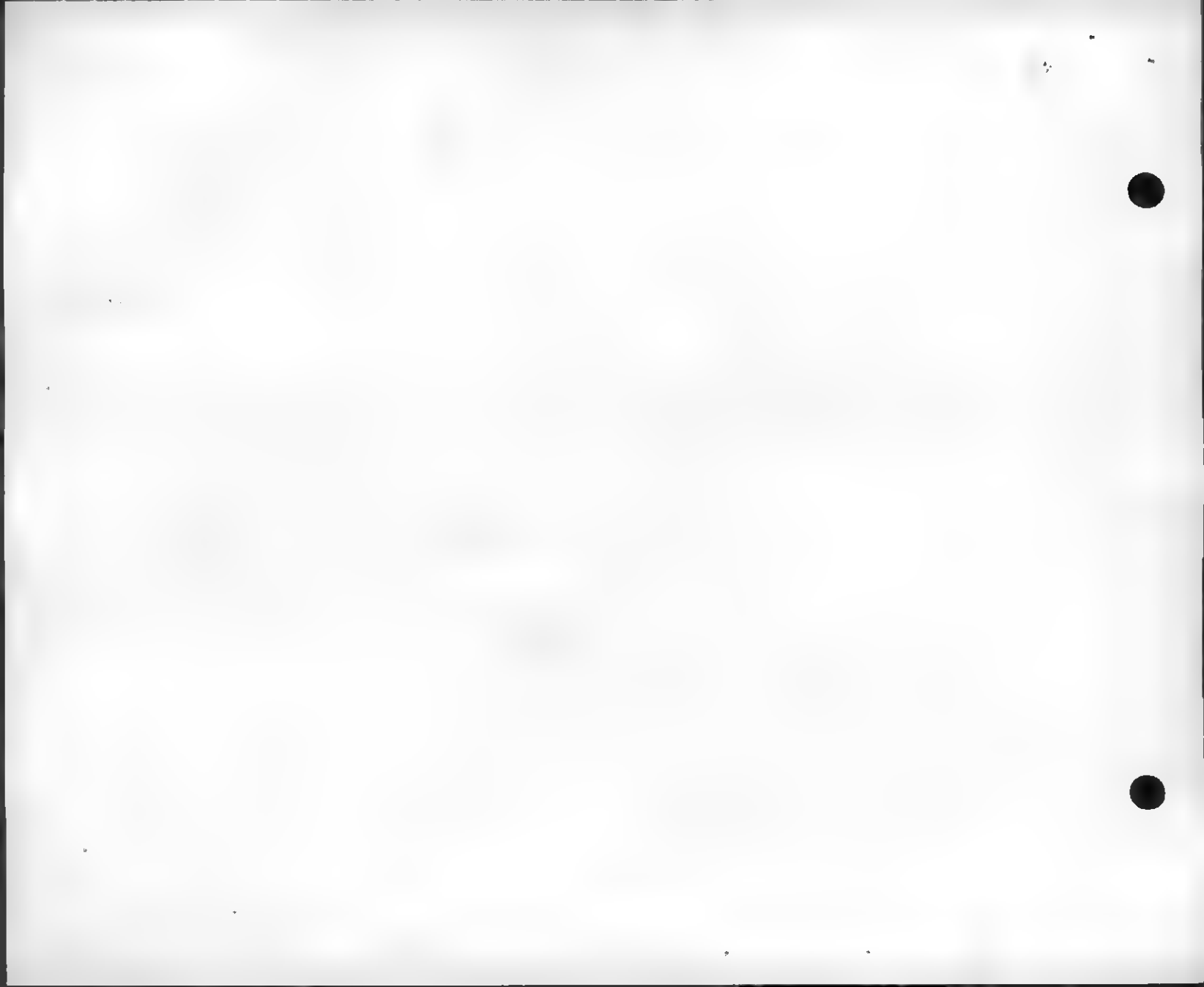


CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <i>Alexander</i>		First Middle Last <i>Krynitsky</i>		2a. DATE OF DEATH Month <i>March</i> Day <i>19</i> Year <i>1968</i>		2b. HOUR <i>9:30 P</i>	
3 SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>11-28-81</i>		6. AGE (in years) last birthday <i>86</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>Russia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (kind of work done during most of working life, even if retired) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Chesapeake</i>		13d. INSIDE CITY (in 15?) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>4902 Cumberland Lane</i>		14 FATHER'S NAME First <i>John</i> Middle <i>Krynitsky</i> Last <i>Unknown</i>		15 MOTHER'S MAIDEN NAME First <i>Wife</i> Middle <i>Helen</i> Last <i>Krynitsky</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	
16b. SOCIAL SECURITY NO		17 INFORMANT <i>Wife</i>		17. ADDRESS <i>Same as Item 13.</i>		18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Thrombosis and Thrombosis</i> <i>410.0</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Cerebral Thrombosis Left Hemisphere</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hypertensive Cardiovascular Disease</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> <i>21 days</i> <i>Years.</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Yes</i>							
9a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No City or Town County State			
22a. I certify that (I) (was hospital) attended the deceased from <i>1952</i> , to <i>date</i> , 19 <i>1968</i> , that (I) (was) last saw the deceased alive on <i>March 19</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>John G. Ball M.D.</i>		DEGREE <i>M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>3/19/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>JOHN G. BALL</i>		22e. ADDRESS <i>7936 Old Georgetown Rd. Bethesda, Maryland</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE <i>3-22-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		23d. LOCATION (City or Town) (County) (State) <i>Suitland, Maryland</i>	
24. FUNERAL DIRECTOR <i>Robert A. Pumphrey, Bethesda, Maryland</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>MAR 26 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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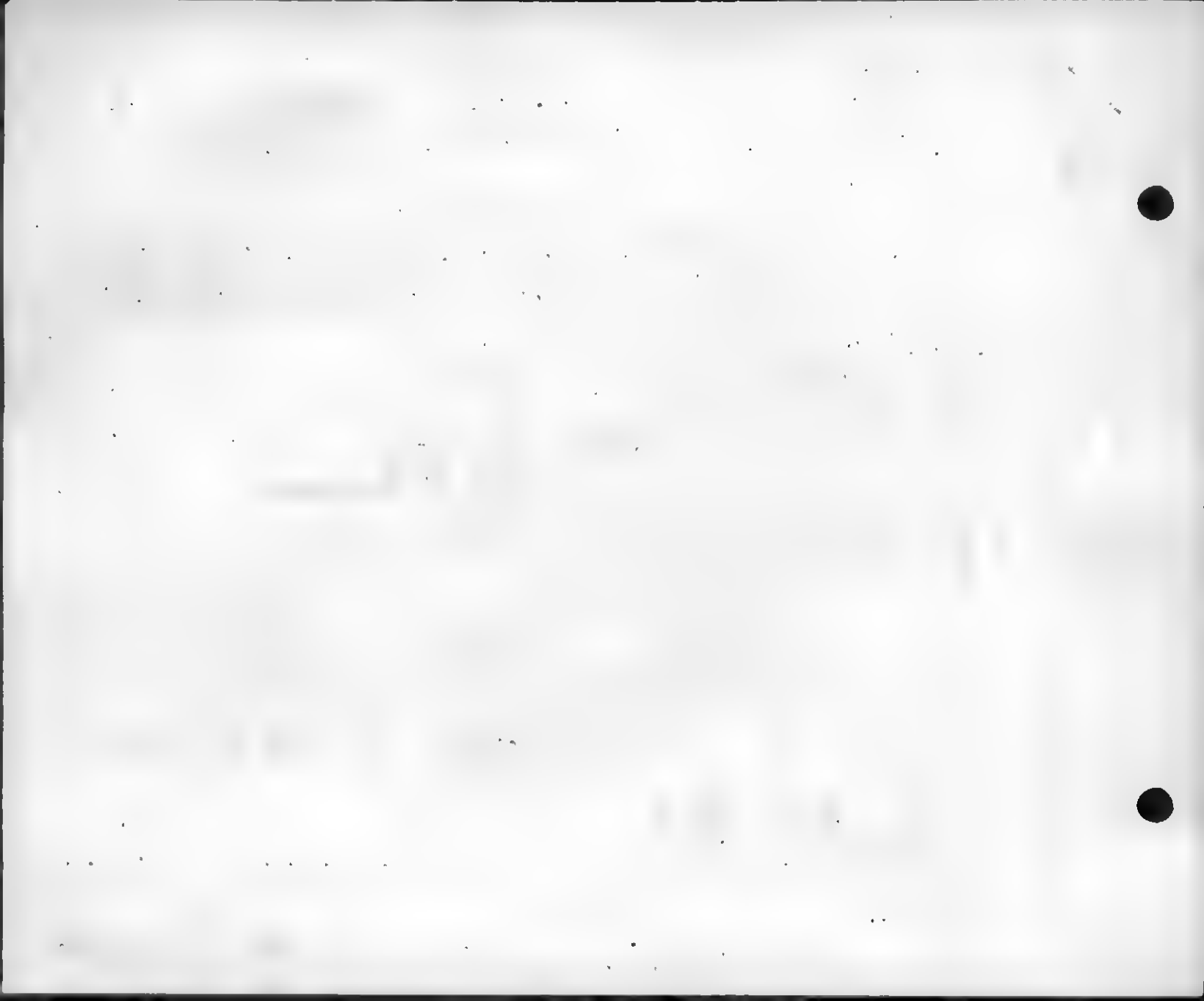
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1385

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) MORRIS		First Middle Last KIM KUSHNER		2a. DATE OF DEATH Month March Day 28 Year 1968		2b. HOUR 7:50 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Unknown		6. AGE (In years last birthday) 78 YRS.	
7a. BIRTHPLACE (State or foreign country) Russia		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Potomac Valley Nursing H.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Auto Reconstruction		12b. KIND OF BUSINESS OR INDUSTRY Auto	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Abraham Kushner		15. MOTHER'S MAIDEN NAME First Middle Last Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 2 1/2 years.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 332X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 10/26 , 19 65 , to 3/28 , 19 68 , that (I) (we) last saw the deceased alive on 3/27 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jack P. Seral				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 3/28/68	
22d. PHYSICIAN'S NAME (Type) Jack P. Seral				22e. ADDRESS 5323 Conn. Ave., N.W., Washington, D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit		23b. DATE 3/29/68		23c. NAME OF CEMETERY OR CREMATORY Local Cemetery		23d. LOCATION (City or Town) (County) (State) Chicago, Illinois	
24. FUNERAL DIRECTOR Lyson Wheeler				ADDRESS Rockville Pike		25a. RECD BY REGISTRAR DATE APR 3 - 1968	
						25b. REGISTRAR'S SIGNATURE Charles J. Jones	



CERTIFICATE OF DEATH

04373

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12224 Hunters Lane</u>		e. STREET ADDRESS <u>12224 Hunters Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>GERTRUDE</u> Middle <u>Ann</u> Last <u>LAHEY</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>15</u> Year <u>1968</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 21, 1890</u>
9. AGE (In years last birthday) <u>77</u> years		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>15</u> Hours <u>15</u> Min <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Thomas Flood</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Kane</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>162-36-4331</u>	
17. INFORMANT <u>Daughter</u>		Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>199.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, / (b) <u>Virus Infection</u> DUE TO (c) <u>Metastatic Generalized Malignancy</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>8 months</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Osteoarthritis, hips & knees, disabling</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>NONE</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>MARCH</u> , 19 <u>65</u> , to <u>MARCH 12</u> , 19 <u>68</u> ; that (I) (we) last saw the deceased alive on <u>Nov 1</u> , 19 <u>67</u> , and that death occurred at <u>908 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Frederick S Caldwell</u>		22b. DATE SIGNED <u>MAR 12, 1968</u>	
22c. PHYSICIAN'S NAME (Type) <u>FREDERICK S CALDWELL</u>		22d. ADDRESS <u>50 W EDMONDSTON DRIVE ROCKVILLE, MD 20852</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-15-68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Scranton, Penna.</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAR 15 1968</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

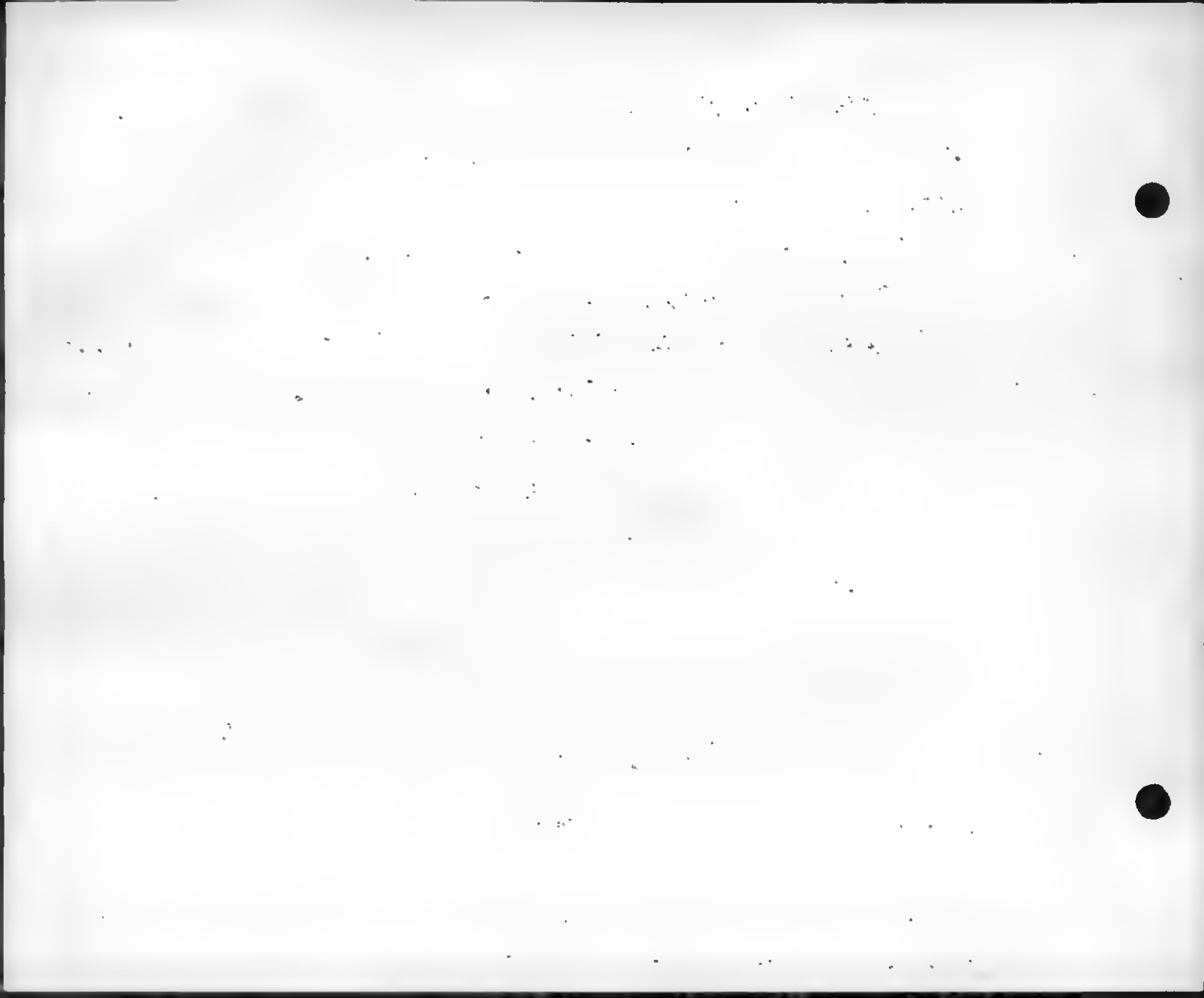
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0438:

CERTIFICATE OF DEATH

04374

1. DECEASED NAME (Type or print) ROY FRANKLIN LAMBERT			2a. DATE OF DEATH Month March Day 14 Year 1968			2b. HOUR 12:15 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 8/15/89		6. AGE (in years last birthday) 78 YRS	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) LABORER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md		13b. COUNTY Mont		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last CHARLES A. LAMBERT		15. MOTHER'S MAIDEN NAME First Middle Last KATE HARMON		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NO			
16b. SOCIAL SECURITY NO. 219-01-1519A		17. INFORMANT Address MRS. Charles FLICKINGER, Taneytown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiovascular collapse 43 DUE TO, OR AS A CONSEQUENCE OF (b) cerebral thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 3307p uremia							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from March 1, 1968 to March 14, 1968 , that (I) (we) last saw the deceased alive on March 14, 1968 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Michael R. Chermontzoff						22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE MAR. 17, 1968		23c. NAME OF CEMETERY OR CREMATORY MT. PLEASANT CEMETERY		23d. LOCATION (City or Town) (County) (State) TANEYTOWN CARROLL, Md.	
24. FUNERAL DIRECTOR John H. Spiles				25a. REC'D BY REGISTRAR MAR 19 1968		25b. REGISTRAR'S SIGNATURE Charles J. J...	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

4375

1. DECEASED-NAME (Type or print)		First LOTTIE	Middle	Last LANDAU	2a. DATE OF DEATH Month March Day 24 Year 1968		2b. HOUR 5 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH May 12, 1898		6. AGE (In years last birthday) 69 YRS		7. UNDECEASED MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md		
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 247 Rollins Avenue		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montg.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 247 Rollins Avenue
14. FATHER'S NAME First Hyman Middle Reiss Last Rose				15. MOTHER'S MAIDEN NAME First Burnstein Middle Rose Last Burnstein				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. none		17. INFORMANT Address Marilyn Kweller 5907 Greentree Rd, Beth., Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 410.9 DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY ATHEROSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) 5+ YEARS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 410.9								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 MINUTES
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ACUTE MYOCARDIAL INFARCTION 2 YEARS AGO								
19a. DATE OF OPERATION MARCH 19, 1968		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED EYE MUSCLE SURGERY		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (the hospital) attended the deceased from 1965 , to MARCH 24, 1968 , that (I) (last) saw the deceased alive on MARCH 24, 1968 , and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Edward A. Beeman M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22c. DATE SIGNED MARCH 24, 1968
22d. PHYSICIAN'S NAME (Type) EDWARD A. BEEMAN, M.D.		22e. ADDRESS 1815 SPRING ST. SILVER SPRING MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-25-68		23c. NAME OF CEMETERY OR CREMATORY Mt. Judah Cem		23d. LOCATION (City or Town) (County) (State) Brooklyn, N.Y.		
24. FUNERAL DIRECTOR Goldberg Funeral Home		ADDRESS 4217 9th St. N.W.		25a. REC'D BY REGISTRAR MAR 26 1968		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

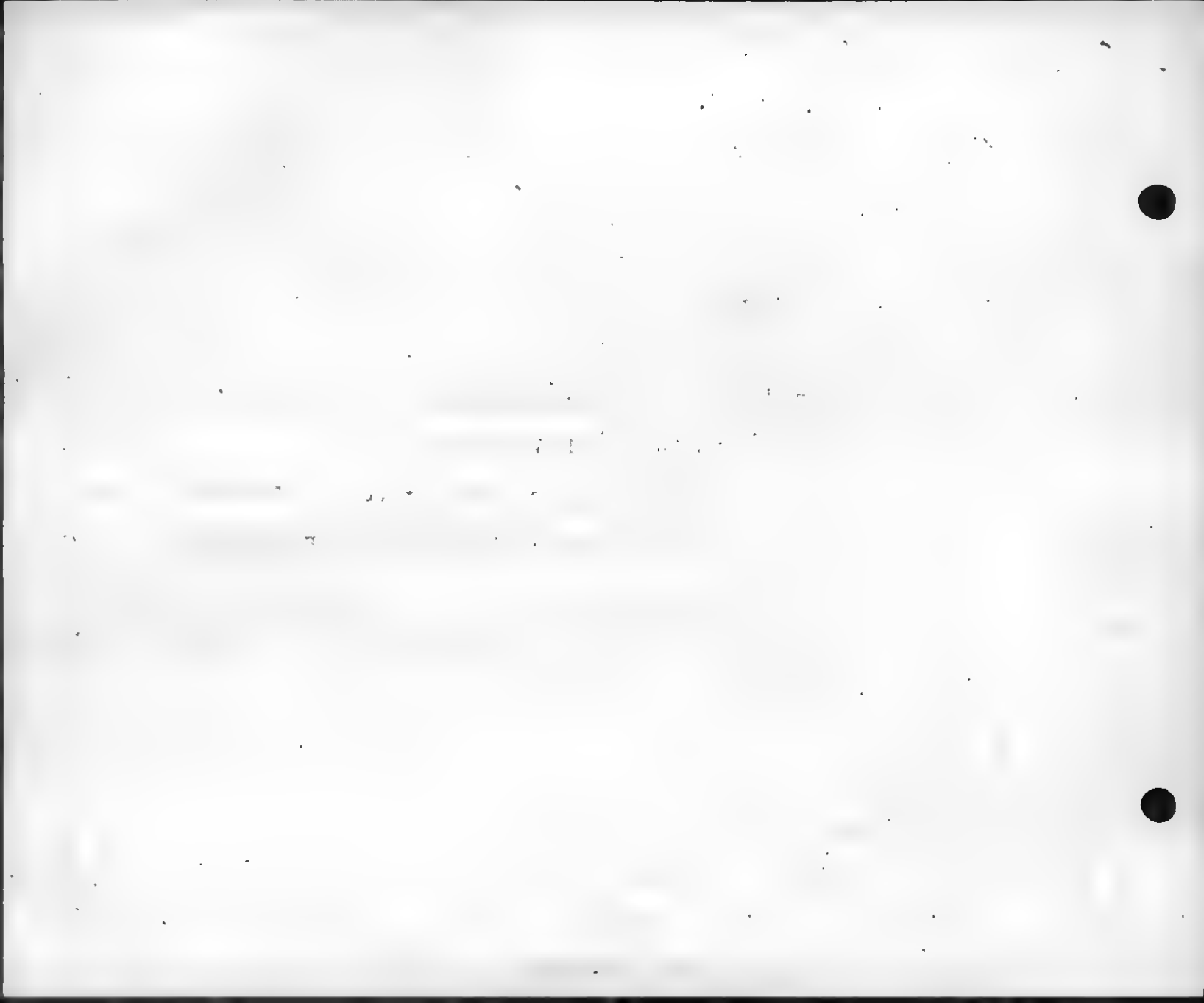


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4383
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

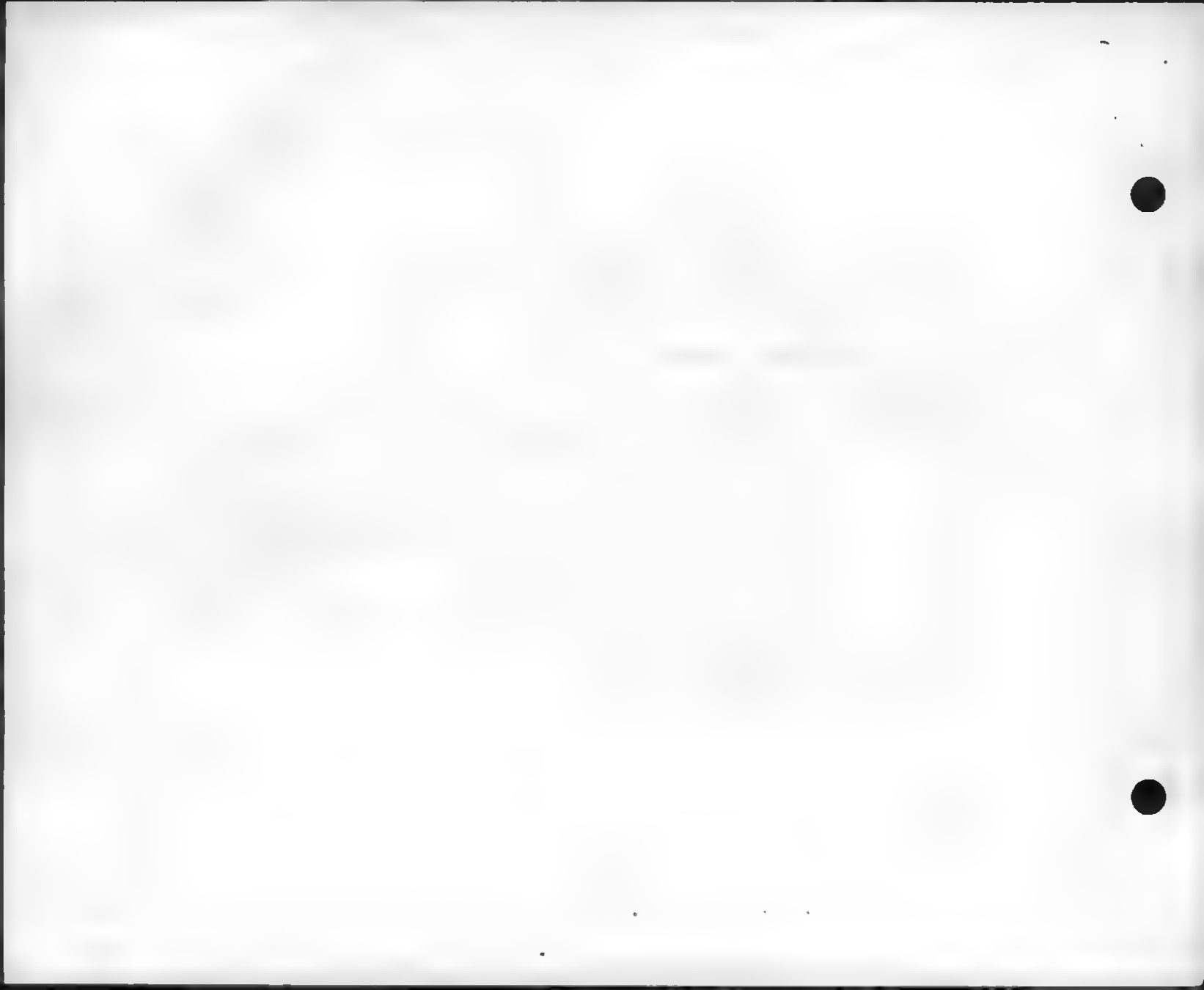
1. DECEASED-NAME (Type or print) MARY First F. Middle Langley Last			2a. DATE OF DEATH Mar. 14 1968 Month Day Year			2b. HOUR 11⁴⁵ AM	
3 SEX Female		4 RACE White		5 DATE OF BIRTH 9/21/08		6 AGE (In years lost birthday) 59 YRS	
7a. BIRTHPLACE (State or foreign country) S. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USLA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 6037 CHESHIRE DRIVE		14. FATHER'S NAME First Oscar Middle Fastw Last		15. MOTHER'S MAIDEN NAME First Florence Middle Finch Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) Yes (If yes give war or dates of service) 1936-1940		16b. SOCIAL SECURITY NO. None		17. INFORMANT Sheldon Aldin Langley Address Same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Massive gastric hemorrhage 1/17X DUE TO, OR AS A CONSEQUENCE OF (b) Carcinomatosis of stomach wall with ulceration DUE TO, OR AS A CONSEQUENCE OF (c) Metastases to primary carcinoma of right breast stating the underlying cause last CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROX. MED. INTERVAL BETWEEN ONSET AND DEATH 8 hours months 1 year	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Nov. , 19 67 , to Mar. 14 , 19 68 , that (I) (we) last saw the deceased alive on Mar. 14 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert G. Brewer DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 3/15/68			
22d. PHYSICIAN'S NAME (Type) ROBERT G. BREWER				22e. ADDRESS 8505 Old Georgetown Rd Bethesda			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-18-68		23c. NAME OF CEMETERY OR CREMATORY Rook Creek Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D. C. Md.	
24. FUNERAL DIRECTOR Robert A. Cummins Bethesda, Md. ADDRESS				25a. RECD BY REGISTRAR MAR 26 1968 DATE		25b. REGISTRAR'S SIGNATURE James J. ...	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

DECEASED NAME (Type or print) <i>Catherine E. Lanzi</i>		First	Middle	Last	2a. DATE OF DEATH Month <i>March</i> Day <i>24</i> Year <i>68</i>			2b. HOUR <i>5:15</i> P.M.	
3 SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>3/22/09</i>			6. AGE (in years last birthday) <i>59</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>New Jersey</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Nurse</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Cherry Chase</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>8805 Kensington Parkway</i>	
14. FATHER'S NAME First Middle Last <i>Joseph Leo</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Angeline Russell</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <i>NO</i>				
16b. SOCIAL SECURITY NO.		17. INFORMANT <i>Mary Kerdack Kensington Parkway</i>					Address <i>1805</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF <i>Coronary artery occlusion</i> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause <i>remote</i> (b) <i>Coronary arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF <i>years</i> (c) <i>years</i>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>3-24, 1968</i> , to <i>3-24, 1968</i> , that (I) (we) last saw the deceased alive on <i>3-24</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Robert R. Montgomery, MD</i>		22c. DATE SIGNED <i>3-25-68</i>		22d. PHYSICIAN'S NAME (Type) <i>ROBERT R. MONTGOMERY</i>		22e. ADDRESS <i>5411 Cedar Lane Bethesda, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>3-29-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Joseph Cemetery</i>		23d. LOCATION (City or town) (County) (State) <i>Newton, New Jersey</i>			
24. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i>		24b. ADDRESS <i>557 Wisc Ave. Beth Md</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>MAR 27 1968</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL: 2. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> c. LENGTH OF STAY IN Ib <u>3 WKS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wheaton Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> d. STREET ADDRESS <u>140 Hesketh St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF (Type or print) First <u>Mary Martha</u> Middle <u>W</u> Last <u>W. Lucas</u> 5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>19 March 1871</u> 9. AGE (In years last birthday) <u>96</u> yrs. IF UNDER 1 YEAR Months <u>9</u> Days <u>9</u> IF UNDER 24 HRS. Hours <u>19</u> Min. <u>68</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Indiana</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Wallace</u> 14. MOTHER'S MAIDEN NAME <u>Smith</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Gertrude W. Lucas</u> Address <u>140 Hesketh St. Cherry Chase, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal broncho pneumonia</u> DUE TO (b) <u>Cardio vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>3 yrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4 yrs.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>May 19, 1968</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1105</u> 20f. (City or town) <u>Mar 9</u> (County) <u>1968</u> (State) <u>1968</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>May 19, 1968</u> that (I) (we) last saw the deceased alive on <u>Mar 9, 1968</u> and that death occurred at <u>11:05 PM</u> from the causes and on the date stated above. 22a. SIGNATURE <u>E. E. Quayle</u> M.D. 22b. DATE SIGNED <u>3-9-68</u> 22c. PHYSICIAN'S NAME (Type) <u>E. E. Quayle M.D.</u> 22d. ADDRESS <u>1822 Baltimore St NW Washington, D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>March 13, 68</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Cave Cemetery</u> 23d. LOCATION (City, town or county) <u>Louisville Kentucky</u> (State) <u>Kentucky</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> 25a. REC'D BY REGISTRAR <u>Mar 14 1968</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) THOMAS J LEONARD, Sr.			2a. DATE OF DEATH Month 3 Day 10 Year 68		2b. HOUR 1:29 M
3 SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH 24 OCT. 1887		6. AGE (In years last birthday) 80 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) MASSACHUSETTS	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY Md		
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CHEVY CHASE NURSING & CONV. CENTER		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) Retired	12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INS. OF CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 1780 EAST-WEST HWY	
14. FATHER'S NAME First Middle Last PATRICK LEONARD		15. MOTHER'S MAIDEN NAME First Middle Last Mary Keenan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) VW I		16b. SOCIAL SECURITY NO. 213-48-3498		17. INFORMANT Wife Anne L. Leonard Address Same as Item 13.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HEPATIC DECOMPENSATION 1538 DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c) ADENO-CA COLON - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 weeks one year
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1538					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1965 19 Mar 10 , 19 68 , that (I) (we) lost saw the deceased alive on Mar 10 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert Kramer		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 3/10/68	
22d. PHYSICIAN'S NAME (Type) ROBERT KRAMER		22e. ADDRESS 8484 16th ST. SS. Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-14-68		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.	
23d. LOCATION (City or Town) (County) (State) Silver Spring, Maryland					
24. FUNERAL DIRECTOR Robert A. Humphrey		ADDRESS Bethesda		25a. REC'D BY REGISTRAR DATE MAR 14 1968	
		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) Leon Lerner		First Middle Last		2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> March 3 1968		2b HOUR 2:15 PM	
3 SEX M.	4 RACE W.	5 DATE OF BIRTH August 30, 1944	6 AGE (in years last birthday) 53 YRS	7 IF UNDER 1 YEAR MONTHS DAYS	8 UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month March Day 3 Year 1968	
7a BIRTHPLACE (State or foreign country) Penn.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery	
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 8600 Springbell Pl.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) MERCHANT		12b KIND OF BUSINESS OR INDUSTRY Hardware	
13a USUAL RESIDENCE (Where deceased lived if institution residence before admission) STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Bethesda		13e STREET AND NUMBER 8600 Springbell Pl.	
14 FATHER'S NAME First Middle Last SAMUEL LERNER				15 MOTHER'S MAIDEN NAME First Middle Last CLARA EIZEN			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO		17 INFORMANT WIFE ADDRESS MRS. ROSALIE LERNER - 8600 SPRINGBELL PL.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Barbiturate Poisoning DUE TO, OR AS A CONSEQUENCE OF Overdose of Barbiturates Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr							1 hr
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION 8/7/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year 2:15 PM 3 3 1968		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) Accidentally took overdose of Tuinal			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f LOCATION Street or R.F.D. No City or Town County State Bethesda Montgomery Md			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John G. Ball		EXAMINER'S NAME (Type) JOHN G. BALL M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED March 4, 1968	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE 3-5-68		23c NAME OF CEMETERY OR CREMATORY MT. LEBANON CEMETERY		23d LOCATION (City or Town) (County) (State) HYATTSVILLE MD	
24 FUNERAL DIRECTOR BERNARD DANZANSKY & SONS - WASH. DC.				25a REC'D BY REGISTRAR MAR 7 1968		25b FILED BY REGISTRAR John G. Ball	



Return by Dr. Ball, Haniel Cravens - JPS

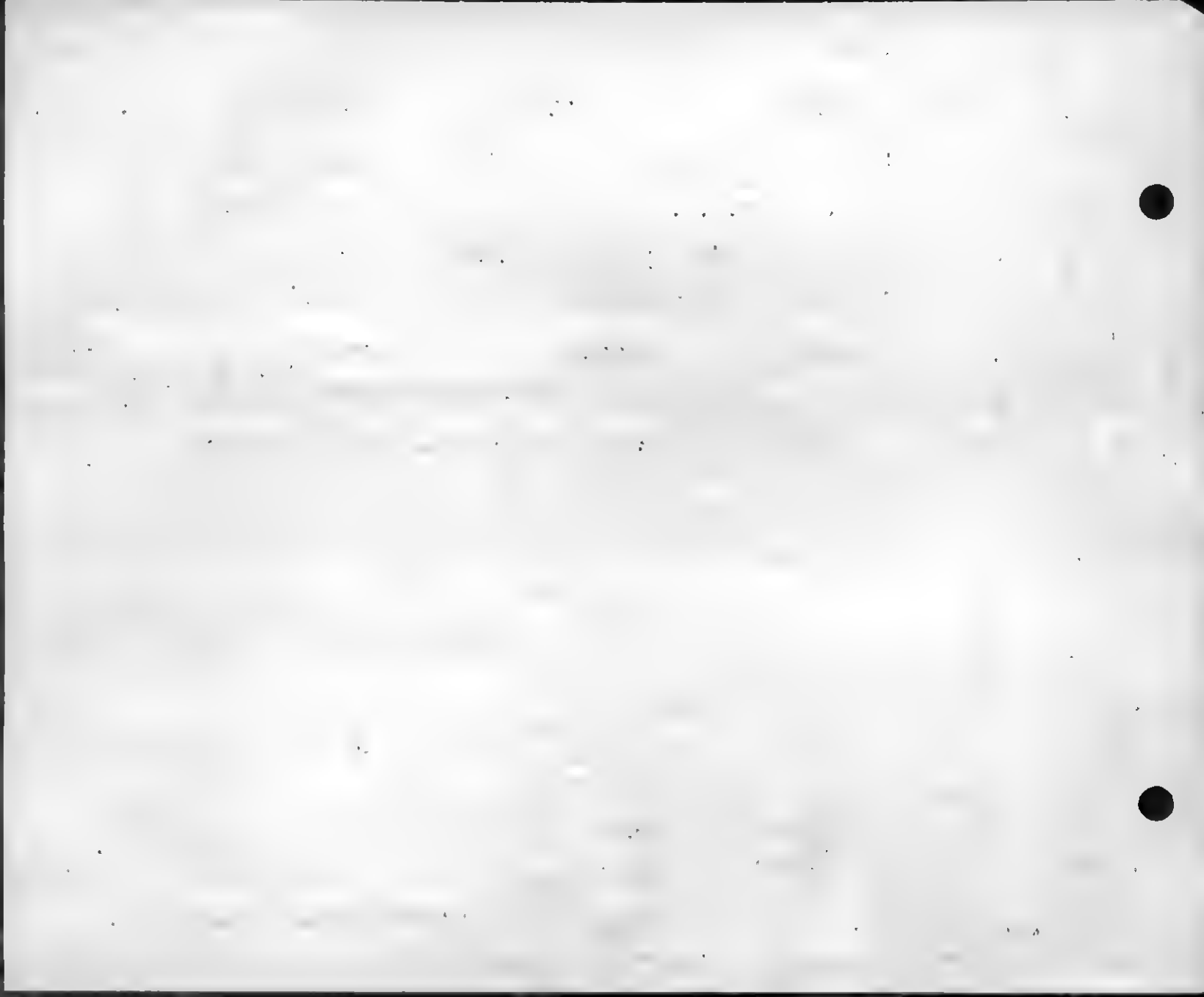
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First MARTHA Middle LIEBERMAN Last LIEBERMAN			2a. DATE OF DEATH Month March Day 19 Year 1968			2b. HOUR 7 A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH June 24, 1904		6. AGE (In years last birthday) 63 YRS	
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4400 East West Hgwy		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Hyman Middle Cohen Last Jennie		15. MOTHER'S MAIDEN NAME First Jennie Middle --- Last ---		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO.		17. INFORMANT Dr. Jack P. Segal Address 7606 Honeywell Lane, Bethesda, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Fibrosis (Fibrosis) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from June , 19 53 , to 3/19 , 19 68 , that (I) (we) last saw the deceased alive on 3/19 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jack P. Segal		22c. PHYSICIAN'S NAME (Type) Jack P. Segal		22d. ADDRESS 5323 Conn. Ave NW		22e. DATE SIGNED 3/19/68	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/20/68		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden		23d. LOCATION (City or Town) (County) (State) Falls Church, Va.	
24. FUNERAL DIRECTOR Bernard Danzansky & Sons		24b. ADDRESS 3501 14th St NW		24c. CITY Washington, DC		24d. REC'D BY REGISTRAR Francis Judge	
24e. DATE MAR 21 1968		24f. REGISTRAR'S SIGNATURE Francis Judge					

MEDICAL CERTIFICATION





439.)

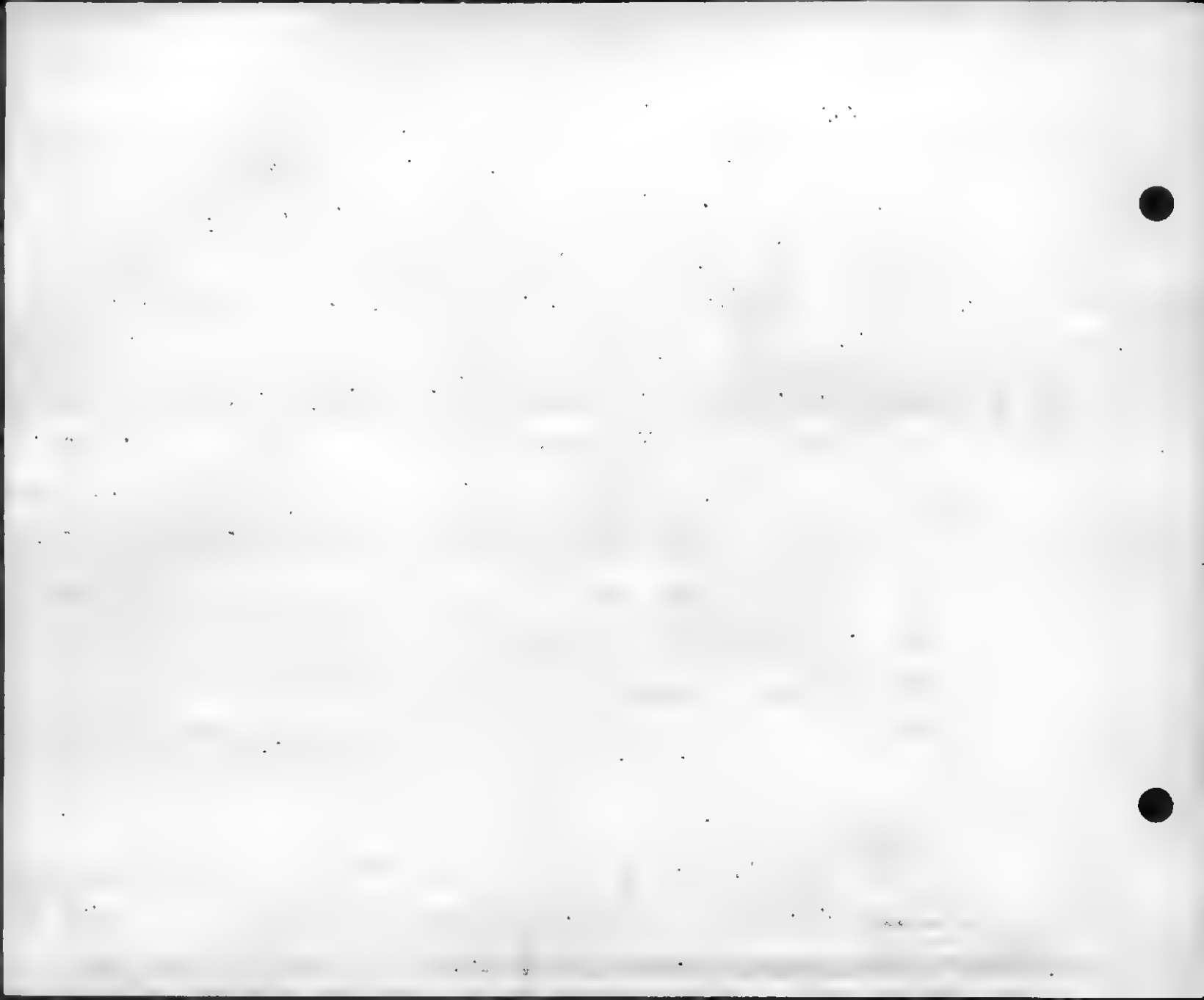
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. DECEASED-NAME (Type or print) First Middle Last <i>Ernest E Lindeberg</i>			2a. DATE OF DEATH Month Day Year <i>Mar 3 68</i>			2b. HOUR <i>5:45 AM</i>	
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>10/16/99</i>		6. AGE (In years last birthday) <i>68</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Sweden</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Montgomery</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>2920 Woodstock Ave.</i>		14. FATHER'S NAME First Middle Last <i>Sven Peter Lindeberg</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Theda Pearson</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>		16b. SOCIAL SECURITY NO. <i>041-10-8933</i>		17. INFORMANT <i>Mrs. Elma Lindeberg</i>		Address <i>(same as 13e.)</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>toxicemia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>metastatic brain carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>left chest squamous carcinoma</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>3 weeks</i> <i>6 wks</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>1. 11-15-67 left chest carcinoma</i>							
19a. DATE OF OPERATION <i>11-15-67</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>left chest carcinoma</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 <i>68</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>6-1-</i> , 1967, to <i>3-3-</i> , 1968, that (I) (we) last saw the deceased alive on <i>3-2-</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>John O. Robben MD</i>				22c. DATE SIGNED <i>3-3-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>John O. Robben MD</i>				22e. ADDRESS <i>10400 CONNETT AVE KENSINGTON</i>			
23a. BURIAL, CREMATION, REMOVAL, (Specify) <i>Burial</i>		23b. DATE <i>March 6, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville Md.</i>	
24. FUNERAL DIRECTOR <i>Charles Walter, Takoma Funeral Home, Inc</i>				25a. REC'D BY REGISTRAR DATE <i>MAR 5 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Walter</i>	



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VR A15 41
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04383

1. DECEASED NAME (Type or print) Daniel Clarence List			2a. DATE OF DEATH Month March Day 10 Year 1968			2b. HOUR 11:26 AM	
3. SEX male		4. RACE WHITE		5. DATE OF BIRTH 3/2/1897		6. AGE (In years last birthday) 71 YRS.	
7a. BIRTHPLACE (State or foreign country) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY PHOTOGRAPHER	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md		13b. COUNTY Mont		13c. CITY OR TOWN Cherry Chase		13d. INSIDE CITY - IN 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 3613 Cherry Chase Rd		14. FATHER'S NAME First Middle Last Daniel Carter List		15. MOTHER'S MAIDEN NAME First Middle Last Clara - Fischer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes (If yes give war or dates of service) Navy		16b. SOCIAL SECURITY NO. 578-32-7632		17. INFORMANT de GRAFFEURIED LIST - WIFE - SAME AS #13		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous cell carcinoma, upper lobe, left lung DUE TO, OR AS A CONSEQUENCE OF with liver metastases. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 163X (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS PLUS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Hypostatic bronchopneumonia. Benign prostatic hypertrophy							
19a. DATE OF OPERATION FEB 2 68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED BRONCHIAL CARCINOMA		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (the hospital) attended the deceased from FEB , 19 68 , to 3-10 , 19 68 , that (I) (the hospital) last saw the deceased alive on 3-10 , 19 68 , and that in (my) (the hospital's) opinion death occurred on the date and hour and from the causes stated above. (I) (the hospital) (did) (did not) view the body after death.							
22b. SIGNATURE J. W. Peabody, Jr. M.D.		22c. DATE SIGNED 3.11.68		22d. PHYSICIAN'S NAME (Type) J. W. PEABODY, JR.		22e. ADDRESS 8512 OLD GEORGETOWN RD. BETHESDA, MD.	
23a. BURIAL CREMATION REMOVAL (Specify) CREMATION		23b. DATE 3/12/68		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY		23d. LOCATION (City or Town) (County) (State) SUITLAND, MD.	
24. FUNERAL DIRECTOR JOS. GAWLER'S SONS, 5130 WIS. AVE. NW, WASH., D.C.		25a. REC'D BY REGISTRAR MAR 14 1968		25b. REGISTRAR'S SIGNATURE [Signature]			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) John		First W	Middle LORENZ	Last	20. DATE OF DEATH Month March Day 6 Year 1968			2b. HOUR 12:47 AM	
3 SEX Male		4. RACE White		5. DATE OF BIRTH 12-4-13			6. AGE (In years last birthday) 54 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Iowa		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md		
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Gifts Ice Cream Protection Mgr.			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY Montgomery			13c. CITY OR TOWN Silver Spring			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
13e. STREET AND NUMBER 1196 Whitmore Terrace			14. FATHER'S NAME First William Middle Louise Last Not Available			15. MOTHER'S MAIDEN NAME First Not Available Middle Not Available Last Not Available			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes Army			16b. SOCIAL SECURITY NO. 119-111111			17. INFORMANT John E. Lorenz			119-111111
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) HSCVD DUE TO, OR AS A CONSEQUENCE OF (c) yes Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 d
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or RFD No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 1964 , to 6 March, 1968 , that (I) (we) last saw the deceased alive on 5 March 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE Horace W. Bernston					DEGREE <input checked="" type="checkbox"/> ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE, SIGNED 3/6/68		
22d. PHYSICIAN'S NAME (Type) HORACE W. BERNSTON					22e. ADDRESS				
23a. BURIAL, CREMATION, REINTERMENT (Specify)		23b. DATE March 9-1968		23c. NAME OF CEMETERY OR CREMATORY St Paul Lutheran Cemetery			23d. LOCATION (City or town) Silver Spring (County) Montgomery (State) Md.		
24. FUNERAL DIRECTOR Arthur H. Haffers		24a. ADDRESS 294 Carroll Street, N.W. Washington, D.C. 20012			25a. RECEIVED BY REGISTRAR DATE MAR 11 1968		25b. REGISTRAR'S SIGNATURE James J. Jones		



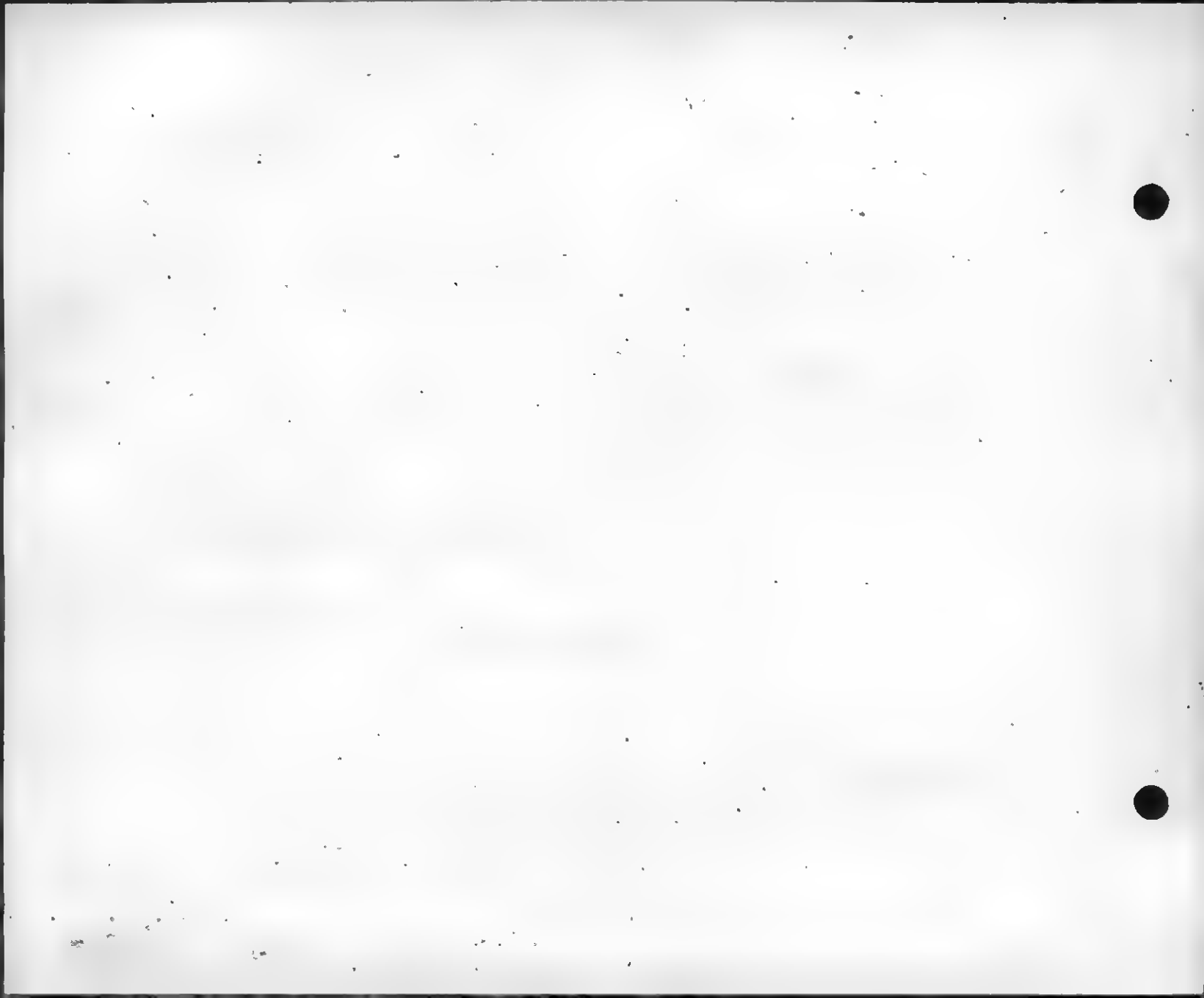
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VR A15 (4)
30M REV. 1-58

MD 395
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <u>James R. Lowrey</u>			2a. DATE OF DEATH Month <u>March</u> Day <u>26</u> Year <u>1968</u>			2b. HOUR <u>7:25</u> PM	
3. SEX <u>male</u>		4. RACE <u>white</u>		5. DATE OF BIRTH <u>11-22-92</u>		6. AGE (In years lost birthday) <u>76</u> YRS	
7a. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md	
10. CITY OR TOWN OF DEATH <u>Bethesda</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>RETIRED</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD</u>		13b. COUNTY <u>Mont.</u>		13c. CITY OR TOWN <u>Bethesda</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <u>9318 - Linden Ave.</u>		14. FATHER'S NAME First <u>Alfred</u> Middle <u>Lowrey</u> Last <u>Lowrey</u>		15. MOTHER'S MAIDEN NAME First <u>Mary</u> Middle <u>Feith</u> Last <u>Feith</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>no</u> (If yes, give war or dates of service)		16b. SOCIAL SECURITY NO <u>577-012-52</u>		17. INFORMANT <u>Evelyn Lowrey</u>		Address <u>same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma, prostate</u> <u>185X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: <u>177X</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Bronchopneumonia</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>67</u> , to <u>MARCH 26</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>MARCH 26</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Leo M. Curtis</u> MD		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>3-26-68</u>	
22d. PHYSICIAN'S NAME (Type) <u>Leo M. Curtis</u> M.D.		22e. ADDRESS <u>821 Wisconsin Ave. Bethesda, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3/28/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Bladensburg, P.G. Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons Inc.</u>				ADDRESS Wash. D.C. <u>5130 Wisc. Av. N.W.</u>		25a. REC'D BY REGISTRAR <u>APR 1, 1968</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



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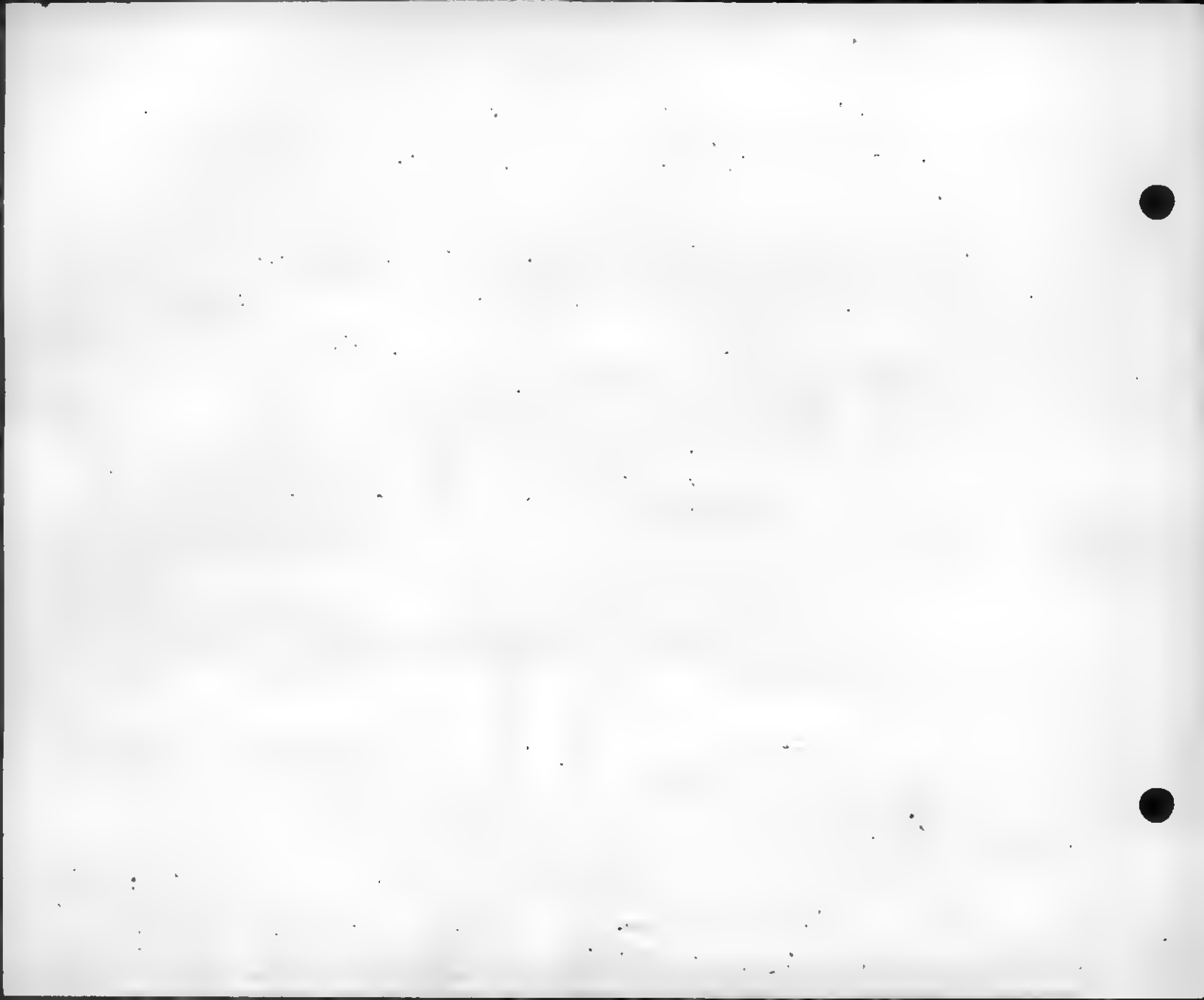
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

22393

24386

1. DECEASED-NAME (Type or print) Willie May Lutes			2a. DATE OF DEATH Month March Day 9 Year 1968			2b. HOUR 2:35 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Jan 26, 1885		6. AGE (In years last birthday) 83 YRS.	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) House wife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Takoma Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Pascal Orange		15. MOTHER'S MAIDEN NAME First Middle Last Mattie J. Wilhelm					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO.		17. INFORMANT Dr's chart.			
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 4120 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive - cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4438						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 40 hours Brown 4 yrs.	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Aug 3, 1964 , to March 9, 1968 , that (I) (we) last saw the deceased alive on March 9, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE David H. Trautman				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED March 10 1968	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS 8237 Georgia Ave Silver Spring Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE March 13-1968		23c. NAME OF CEMETERY OR CREMATORY Lebanon Park		23d. LOCATION (City or Town) (County) (State) Rockville Md	
24. FUNERAL DIRECTOR Arthur Walters		ADDRESS 254 Carroll St		25a. RECD BY REGISTRAR DATE MAR 13 1968		25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04387

1. DECEASED-NAME (Type or print) <i>Henry Elmer Maas</i>			2a. DATE OF DEATH Month <i>March</i> Day <i>18</i> Year <i>1968</i>			2b. HOUR <i>2 P M</i>	
3. SEX <i>Male</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>2/29/91</i>		6. AGE (In years last birthday) <i>77</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>Illinois U.S.A.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Milk man</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>private</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>1001 Rockville Pike</i>		14. FATHER'S NAME First Middle Last <i>(Unknown) Maas</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Anna Beckman</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16b. SOCIAL SECURITY NO. <i>329-032529</i>		17. INFORMANT <i>Emma Maas</i>		Address <i>same as above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac arrest</i> <i>411</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>coronary insufficiency</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>15 yrs.</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4.</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)		21c. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan</i> , 19 <i>67</i> , to <i>Mar</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>March 19 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Marvin Wadler, M.D.</i>		DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>3/18/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>MARVIN WADLER, M.D.</i>		22e. ADDRESS <i>8218 Viac. Av. Beth., Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3-22-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore Natl Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Maryland</i>	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>				25a. REC'D BY REGISTRAR <i>MAR 26 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Marvin Wadler</i>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) LEON McKinley Manwarren			2a. DATE KNOWN OF DEATH Month 3 Day 24 Year 1968		2b. HOUR 12:12M
3. SEX M	4. RACE W	5. DATE OF BIRTH 6/02/95	6. AGE (In years last birthday) 72 YRS	7. IF UNDER 24 HRS MONTHS _____ DAYS _____ HOURS _____ MIN _____	2c. DATE PRONOUNCED DEAD Month Mar Day 24 Year 1968
7a. BIRTHPLACE (State or foreign country) Montgomery, New York		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virginia		13b. COUNTY Georgetown	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1138 Harrison St.	
14. FATHER'S NAME First Ira Middle Manwarren Last Manwarren			15. MOTHER'S MAIDEN NAME First Ann Middle Manwarren Last Manwarren		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WWT		16b. SOCIAL SECURITY NO 574-05-1381	17. INFORMANT Ann Bruce Manwarren Address 1200 N. Court House		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhage. Rt. Intracerebral Massive DUE TO, OR AS A CONSEQUENCE OF (b) Arterio Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 4 years					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 331X					
19a. DATE OF OPERATION 3/24/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No _____ City or Town _____ County _____ State _____	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John S. Bell		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED March 24, 1968	
EXAMINER'S NAME (Type) John S. Bell		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ADDRESS (Street, city, town or county) 2847 Wilson Blvd. Arlington, Va.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/24/68		23c. NAME OF CEMETERY OR CREMATORY Daysville Cemetery	
24. FUNERAL DIRECTOR Ives Funeral Home		23d. LOCATION (City or Town) (County) (State) Mexico, New York		23e. REC'D BY REG. STRAR Mar 27 1968	
23f. REGISTRAR'S SIGNATURE John S. Bell		23g. REGISTRAR'S SIGNATURE John S. Bell			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1a. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
TOM REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) AGNES T MANYETTE			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTI- MATED 3-6 19 68 6 P M		
3 SEX Female	4 RACE Wh.	5 DATE OF BIRTH 7/14/99	6 AGE (In years last birthday) 68 YRS	IF UNDER 1 YEAR MONTHS DAYS 	IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) D.C.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) Retired	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md		13b COUNTY Montgomery Sil.Spr.	13c CITY OR TOWN Sil.Spr.	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 1010 August Dr.
14 FATHER'S NAME First John Middle Haphin Last Mary		15 MOTHER'S MAIDEN NAME First Edith Middle Holden Last Holden		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16b SOCIAL SECURITY NO. 		17 INFORMANT Hospital record		ADDRESS 	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Confagration Burns DUE TO, OR AS A CONSEQUENCE OF 50% Body Surface (b) Accidentally Occurred. DUE TO, OR AS A CONSEQUENCE OF (c) 					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 710					
19a DATE OF OPERATION 3-4-68		19b CONDITION FOR WHICH OPERATION WAS PERFORMED? 		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH Deceased burned self (clothing) while smoking in bed.		21b TIME OF INJURY Month, Day, Year 2-3-4 19 68		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) Deceased burned self (clothing) while smoking in bed.	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f LOCATION Street or R.F.D. No. 1810 August Dr. City or town Silver Sp. County Montgomery State Md.	
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Belden R. Reap MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED MARCH 7, 1968	
EXAMINER'S NAME (Type) BELDEN R. REAP		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town or county) Wash D.C.	
23a BURIAL, CREMATION REMOVAL (Specify) Burial		23b DATE 3/9/1968		23c NAME OF CEMETERY OR CREMATORY Cedar Hill	
24 FUNERAL DIRECTOR Robert A Mattingly		ADDRESS 151-122 1st St N.E.		23d LOCATION (City or Town) (County) (State) Suitland, Maryland	
25a REC'D BY REGISTRAR Charles J. Jones		25b REGISTRAR'S SIGNATURE Charles J. Jones		DATE MAR 8 1968	

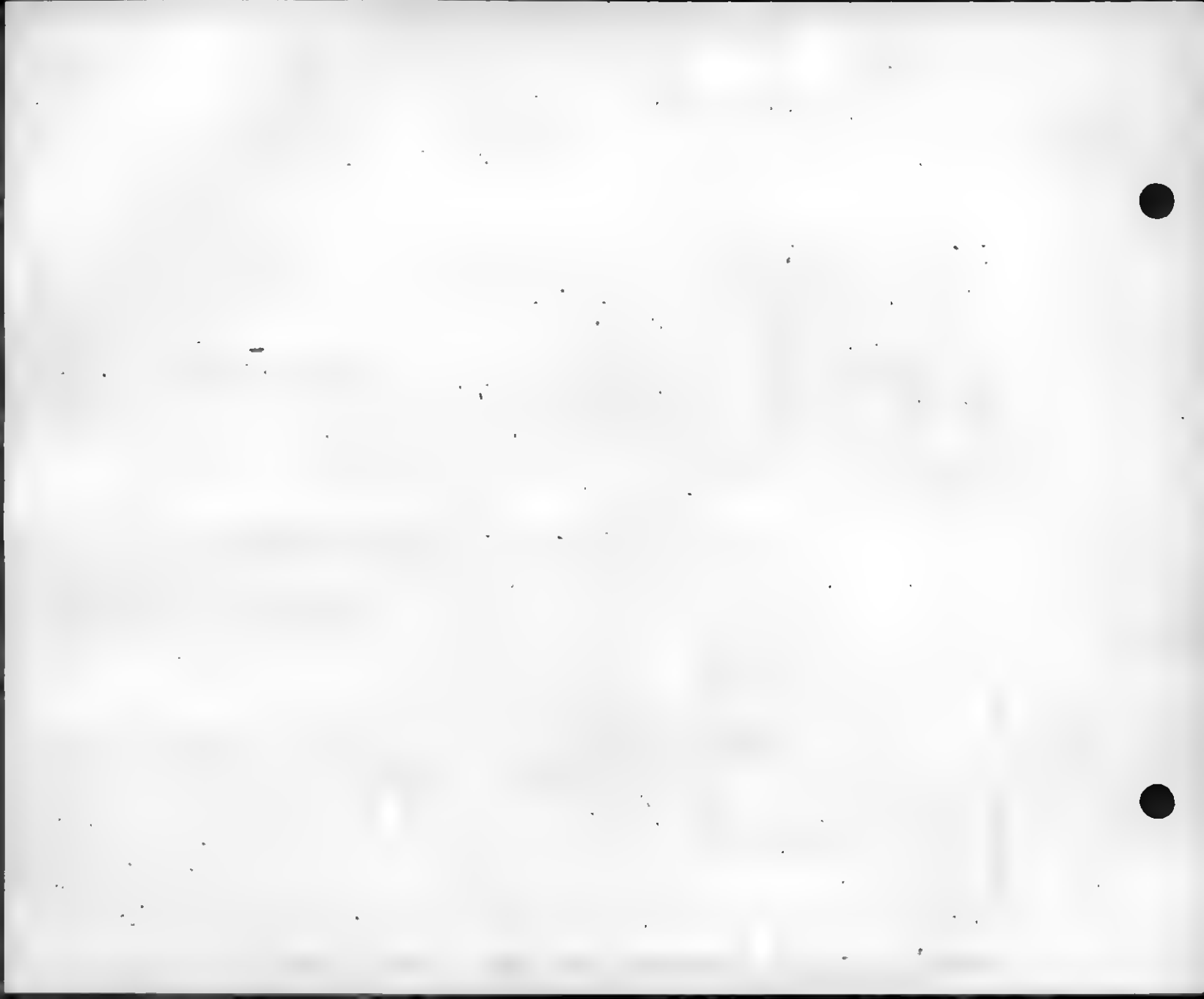


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD 2500
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

DECEASED-NAME (Type or print) RAY (RACHAEL)		First	Middle	Last	2a. DATE OF DEATH Month 11 Day 3 Year 68	2b. HOUR 11:05 M
3. SEX Female	4. RACE Hebrew	5. DATE OF BIRTH 11-29-82			6. AGE (In years lost birthday) 85 YRS.	IF UNDER 1 YEAR MONTHS 4 DAYS 18
7a. BIRTHPLACE (State or foreign country) Europe	7b. CITIZEN OF WHAT COUNTRY? American	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH TAKOMA PARK	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASH. SAN & Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None		12b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MD	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN TAKOMA PARK	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 711 Hudson AVE		
14. FATHER'S NAME First MARCUS Middle Schlom Last LEVA - UNKNOWN		15. MOTHER'S MAIDEN NAME First LEVA - UNKNOWN Middle Address Last MILTON MARGOLIS SAME AS #13				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO NONE		17. INFORMANT CHART		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4120 IMMEDIATE CAUSE (a) Cerebrovascular Accident with rt. hemiplegia 2 days DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis, generalized DUE TO, OR AS A CONSEQUENCE OF (c) CARDIO-VASCULAR RENAL Disease PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cerebral Insufficiency & Cardiomegaly						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21a. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 1958 , 19 68 , to 3-11-68 , that (I) (we) last saw the deceased alive on 3-11-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Samuel A. Hillman DEGREE				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 3-11-68
22d. PHYSICIAN'S NAME (Type) SAMUEL A. HILLMAN				22e. ADDRESS 8829 FLOWER AVE SILVER SPRING, MD 20901		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 12 MAR 1968	23c. NAME OF CEMETERY OR CREMATORY LEE PARK CEMETERY		23d. LOCATION (City or Town) (County) (State) WILKES-BARRE, PENN'A.		
24. FUNERAL DIRECTOR W.W. CHAMBERS Co RIVERDALE, Md. PMS-				25a. RECD BY REG. STAR MAR 13 1968		25b. REGISTRAR'S SIGNATURE Charles Jones



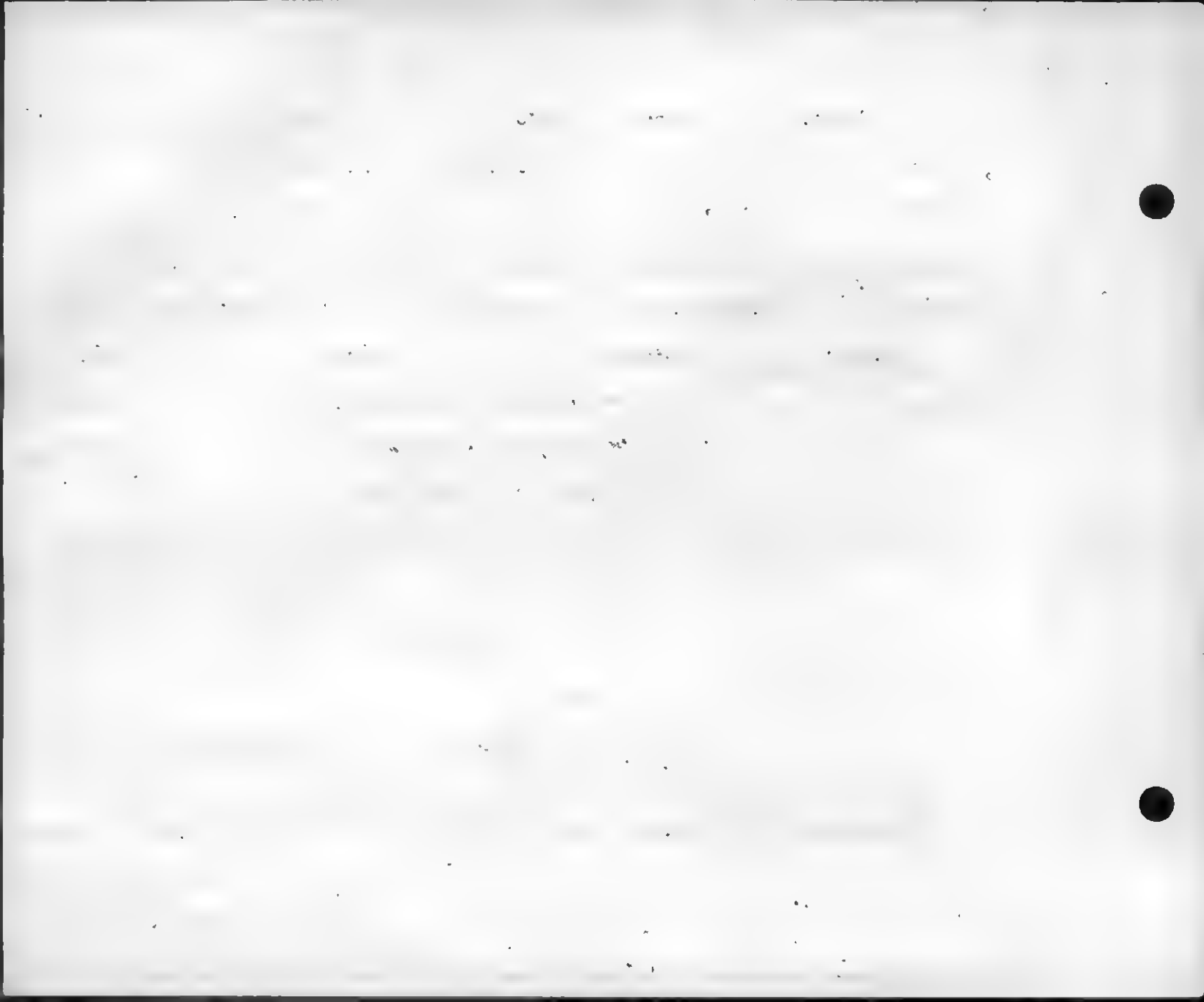
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Frank Ernest Marsh			2a. DATE OF DEATH Month Day Year March 19 1968			2b. HOUR P 11:4^M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH September 27 1901 66 YRS		6. AGE (In years last birthday) MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) England		7b. CITIZEN OF WHAT COUNTRY? America		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired.) Engraver-retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUA. RES. DENT. (Where deceased lived, if institution. Res. den. before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Takoma Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 8205 Garland Avenue		14. FATHER'S NAME First Middle Last Edward Marsh		15. MOTHER'S MAIDEN NAME First Middle Last Emily Taylor		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) no	
16b. SOCIAL SECURITY NO. 214-36-3073		17. INFORMANT Patient's chart		Address 214-36-3073			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute coronary artery thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 33 hours Known System	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from March 18, 1968 , to March 19, 1968 , that (I) (we) last saw the deceased alive on March 19, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Harold H. Trauer MD				22c. DATE SIGNED March 19 1968		22d. PHYSICIAN'S NAME (Type) 8237 Georgia Ave - Silver Spring, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE March 22-1968		23c. NAME OF CEMETERY OR CREMATORY St. Luke's		23d. LOCATION (City or Town) (County) (State) Washington, D.C.	
24. FUNERAL DIRECTOR Frank J. Taylor		25a. REC'D BY REGISTRAR DATE MAR 26 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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240.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First DALLAS	Middle PURDUM	Last McATEE	2a. DATE OF DEATH 3 ^{Month} 27 ^{Day} 68 ^{Year}		2b. HOUR 6:00 P.M.
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 6-15-79		6. AGE (In years last birthday) 88 YRS.	IF UNDER 1 YEAR MONTHS 9 DAYS 12 IF UNDER 24 HRS. HOURS M.N.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery County Md	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13e. STREET AND NUMBER 211 Cedar Avenue	
14. FATHER'S NAME First Middle Last William McAttee		15. MOTHER'S MAIDEN NAME First Middle Last Virginia Purdum					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 214-36-2024		17. INFORMANT Address Admission Recd., Montg. Gen. Hosp., Olney, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Terminal Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis Heart Disease</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>11-15</u> , 19 <u>67</u> , to <u>3-27</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>3-27</u> - 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>E. J. Leal</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <u>E. J. Leal</u>				22e. ADDRESS <u>Gaithersburg Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>3/30/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Darnestown</u>		23d. LOCATION (City or Town) (County) (State) <u>Darnestown, Montg. Md.</u>	
24. FUNERAL DIRECTOR <u>Lyson Wheeler Funeral Home</u>				25a. REC'D BY REGISTRAR <u>APR 3 - 1968</u>		25b. REGISTRAR'S SIGNATURE <u>James J. J...</u>	

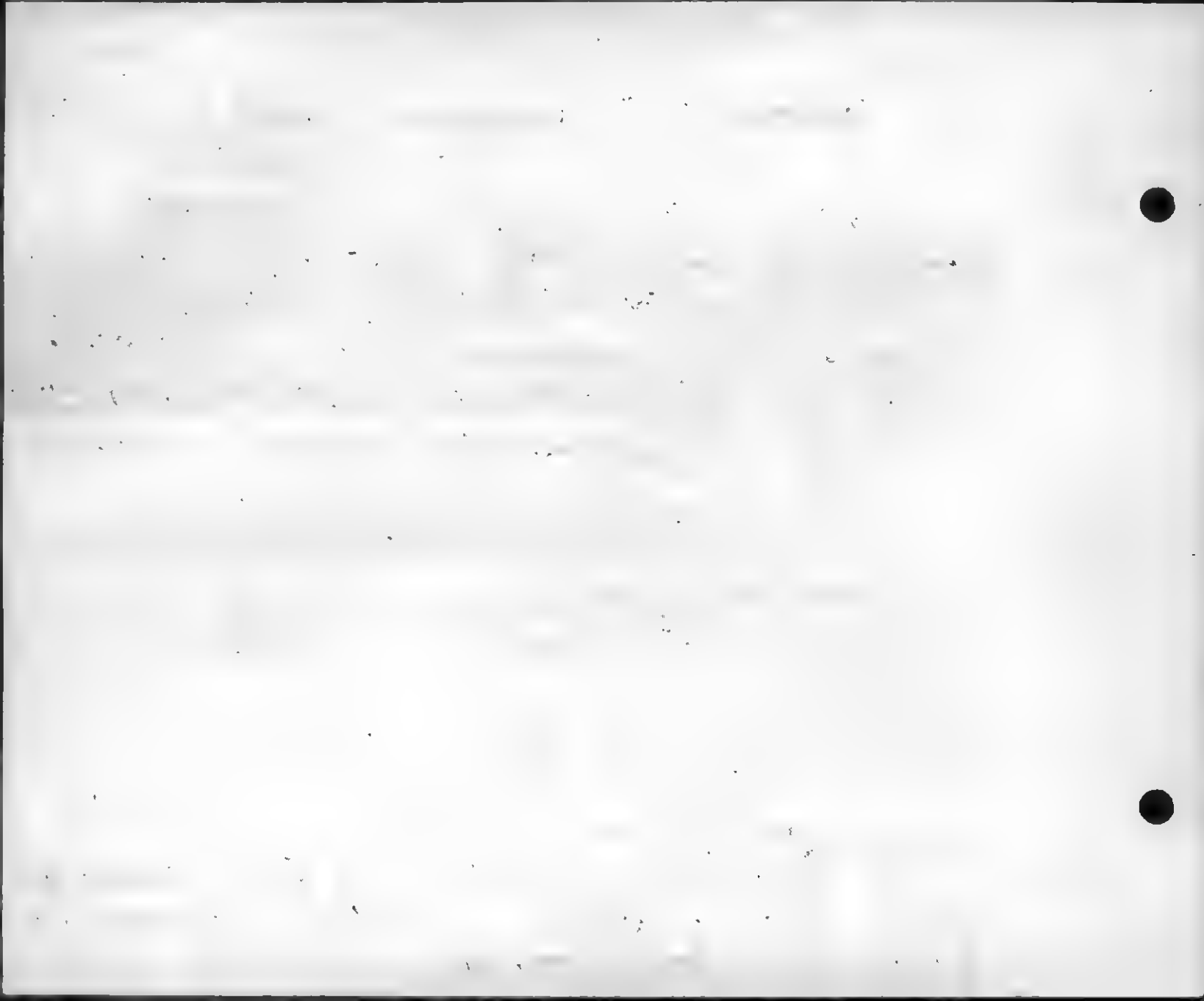


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last Roland J McIntyre			2a. DATE OF DEATH Month Day Year March 8 1968			2b. HOUR Min 9:30	
3. SEX M		4. RACE White		5. DATE OF BIRTH 4-6-02		6. AGE (In years lost birthday) 65 YRS.	
7a. BIRTHPLACE (State or foreign country) ST LOUIS MO.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) ARTIST		12b. KIND OF BUSINESS OR INDUSTRY NEWSPAPER	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD		13b. COUNTY FREDERICK		13c. CITY OR TOWN MT AIRY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER RT. #1		14. FATHER'S NAME First Middle Last JAMES D. MCINTYRE		15. MOTHER'S MAIDEN NAME First Middle Last ELIZABETH MARTIN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 578-10-2214		17. INFORMANT Address MADELINE MCINTYRE RT. #1 MT AIRY, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Bladder 180 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) metastases - Uterus DUE TO, OR AS A CONSEQUENCE OF (c) C Uteral Obstruction APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mo's							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus							
19a. DATE OF OPERATION Jan 1968		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of Bladder		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year PM 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Jan 8 1968 to April 19 68 , that (I) (we) lost saw the deceased alive on Jan 8 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Joseph Bloom MD		22c. PHYSICIAN'S NAME (Type) JOSEPH BLOOM		22d. ADDRESS 1111 SPRING ST. SILVER SPRING, MD.		22e. DATE SIGNED 3/9/68	
23a. BURLING, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2-12-68		23c. NAME OF CEMETERY OR CREMATORY PRESBYTERIAN CEM.		23d. LOCATION (City or Town) (County) (State) HOLLISDAYSBURG PA.	
24. FUNERAL DIRECTOR SALAMONE FUNERAL HOME FREDERICK, MD.		25a. REC'D BY REGISTRAR DATE MAR 11 1968		25b. REGISTRAR'S SIGNATURE James J. Jones			

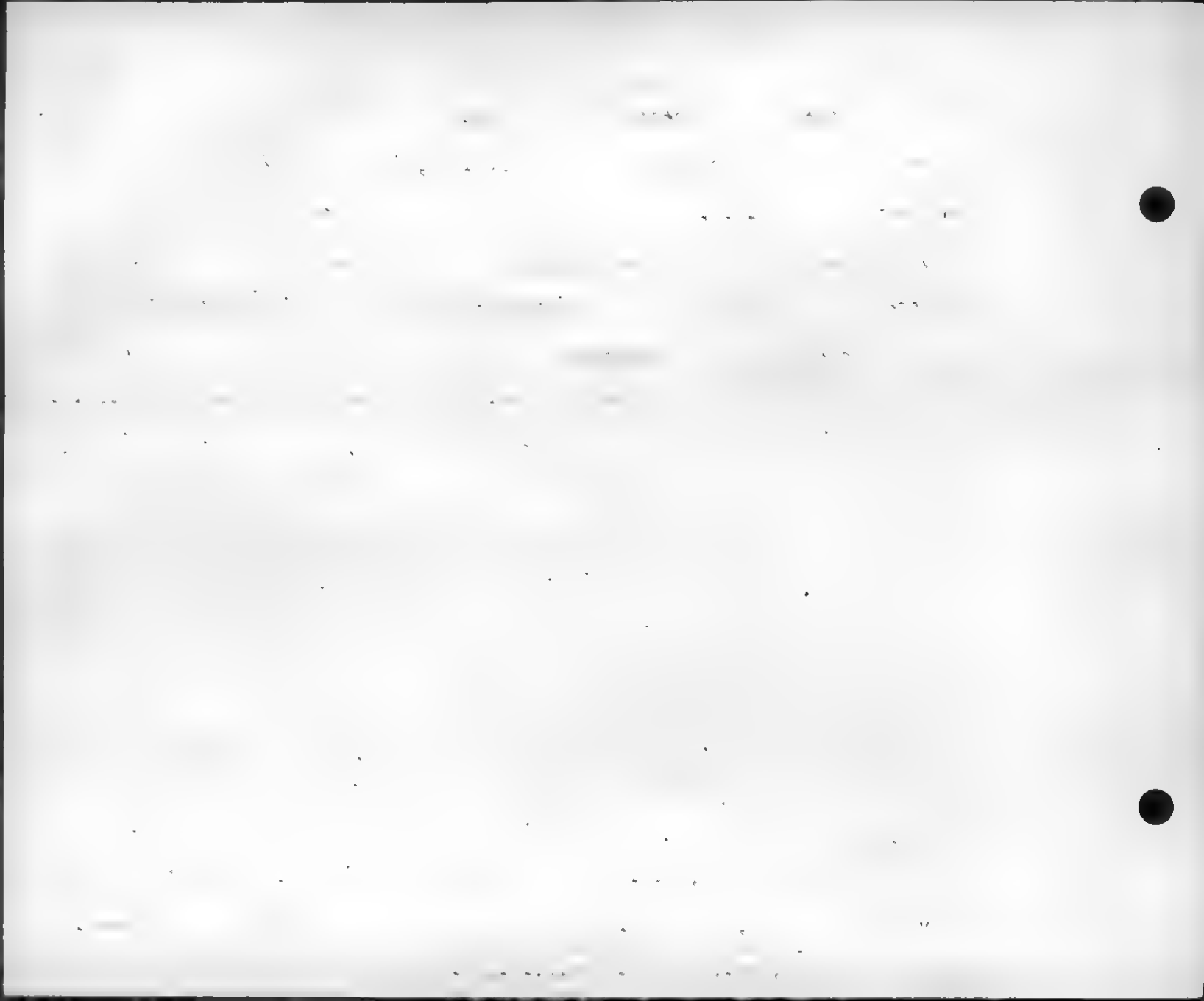


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First <u>Maury</u> Middle <u>Teressa</u> Last <u>Mead</u>			2a. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>68</u>		2b. HOUR <u>9:4</u> M
3 SEX <u>Female</u>	4 RACE <u>Caucasian</u>	5. DATE OF BIRTH <u>Feb. 22, 1892</u>		6 AGE (In years last birthday) <u>76</u> YRS	7. UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u>
7a. BIRTHPLACE (State or foreign country) <u>New York</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <u>Montgomery</u> Md					
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>3902 Randolph Road</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Housewife</u>	
12b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>					
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Montgomery</u>	13c. CITY OR TOWN <u>Silver Spring</u>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <u>3902 Randolph Road</u>
14. FATHER'S NAME First <u>Michael R</u> Middle <u>Cosgrove</u> Last <u>Ann</u>			15. MOTHER'S MAIDEN NAME First <u>Ann</u> Middle <u>McGuirk</u> Last <u>McGuirk</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. John McDonald 3902 Randolph Rd. S.S. Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer of Colon</u> <u>153.8</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO, OR AS A CONSEQUENCE OF (c) <u> </u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Generalized Atherosclerosis</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <u> </u> Month <u> </u> Day <u> </u> Year <u>19</u> P.M. <u> </u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)	
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. <u> </u> City or Town <u> </u> County <u> </u> State <u> </u>	
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 13, 1966</u> to <u>May 2, 1968</u> , that (I) (we) last saw the deceased alive on <u>May 2, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <u>did not</u> view the body after death.					
22b. SIGNATURE <u>John J. Curry M.D.</u>		22c. DATE SIGNED <u>3/2/68</u>		22d. PHYSICIAN'S NAME (Type) <u>John J. Curry, M.D.</u>	
22e. ADDRESS <u>9801 Georgia Ave., Silver Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>March 5, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John's</u>	
23d. LOCATION (City or Town) <u>Pittston</u>		(County) <u>Penn.</u>		(State) <u>Penn.</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc., 8434 Ga. Ave., S.S. Md.</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 8 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

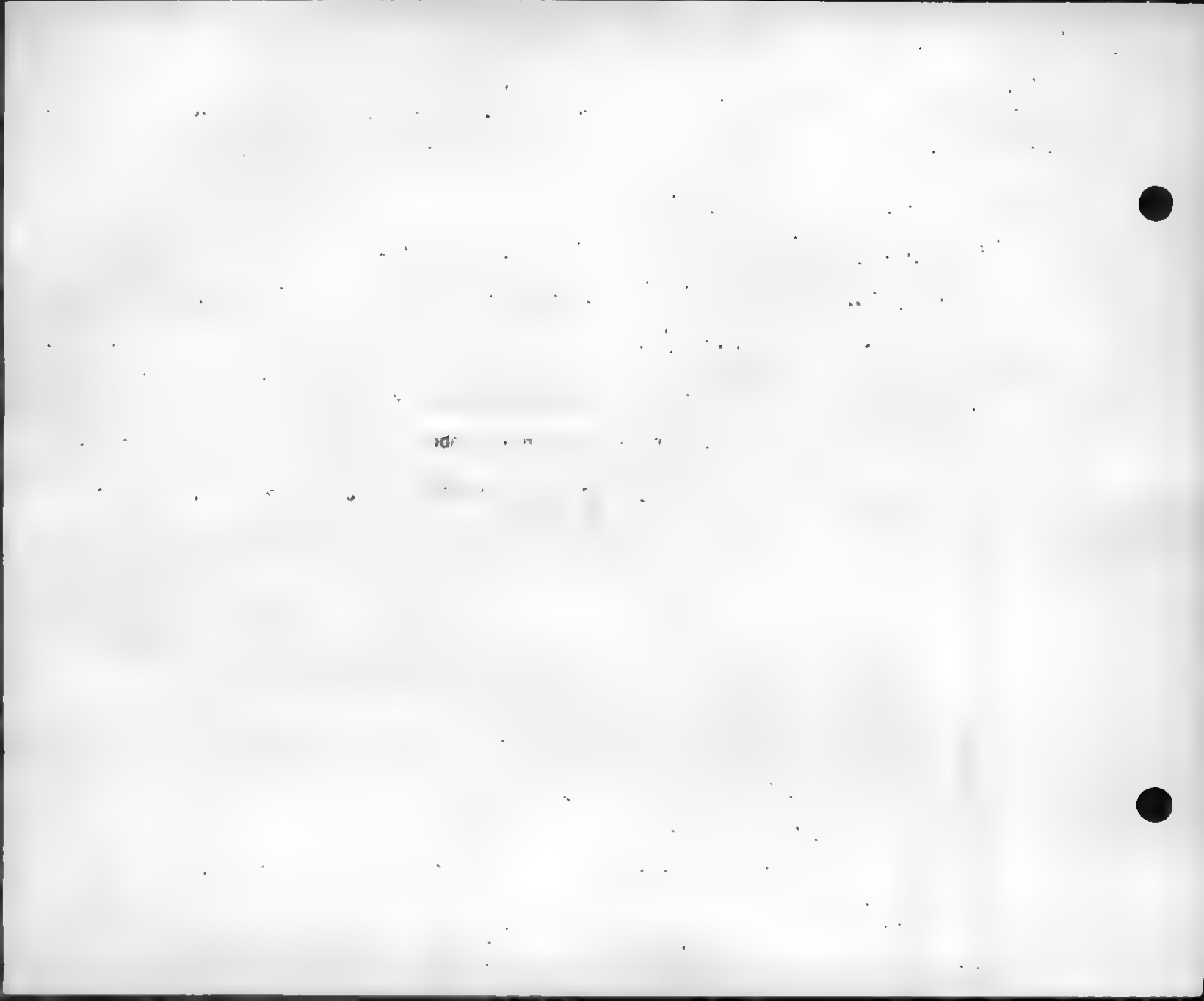


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MEDICAL CERTIFICATION

1 DECEASED-NAME (Type or print) First Middle Last VERNE Mary Metcalfe		2a DATE OF DEATH Month Day Year 3 24 68		2b HOUR 8:45 PM	
3 SEX F		4 RACE W.		5. DATE OF BIRTH 10/14/03	
6. AGE (In years last birthday) 1-4 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Pa.		7b. CITIZEN OF WHAT COUNTRY? American		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Montgomery Md		10. CITY OR TOWN OF DEATH Takoma Park		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Suburban Hospital	
12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	
13b COUNTY PG		13c CITY OR TOWN Adelphi		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 1822 Metzgeroff Rd		14 FATHER'S NAME First Middle Last F. W. Schuster		15 MOTHER'S MAIDEN NAME First Middle Last Millie Anderson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) NO		16b SOCIAL SECURITY NO 215-38-3516		17 INFORMANT Hospital Record Address T.P. Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple pulmonary emboli, acute</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Associated with arteriosclerotic Heart Dis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 hours to 5 min. Years _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building etc.)		21f LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 3/23, 1968, to 3/24, 1968, that (I) (we) last saw the deceased alive on 3/24/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Abraham Danish</i>		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) Abraham Danish, M.D.		22e. ADDRESS Silver Spring, Maryland			
22c. DATE SIGNED 3/24/68					
23a BURIAL, CREMATION REMOVAL (Specify) Burial		23b DATE 27 March		23c NAME OF CEMETERY OR CREMATORY FORTH LINCOLN CEM	
23d LOCATION (City or Town) (County) (State) COLMAR MANOR MARYLAND		23e ADDRESS Wash. D.C.		23f REC'D BY REGISTRAR DATE MAR 26 1968	
24 FUNERAL DIRECTOR W. W. Chambers		25 REGISTRAR'S SIGNATURE <i>W. W. Chambers</i>			

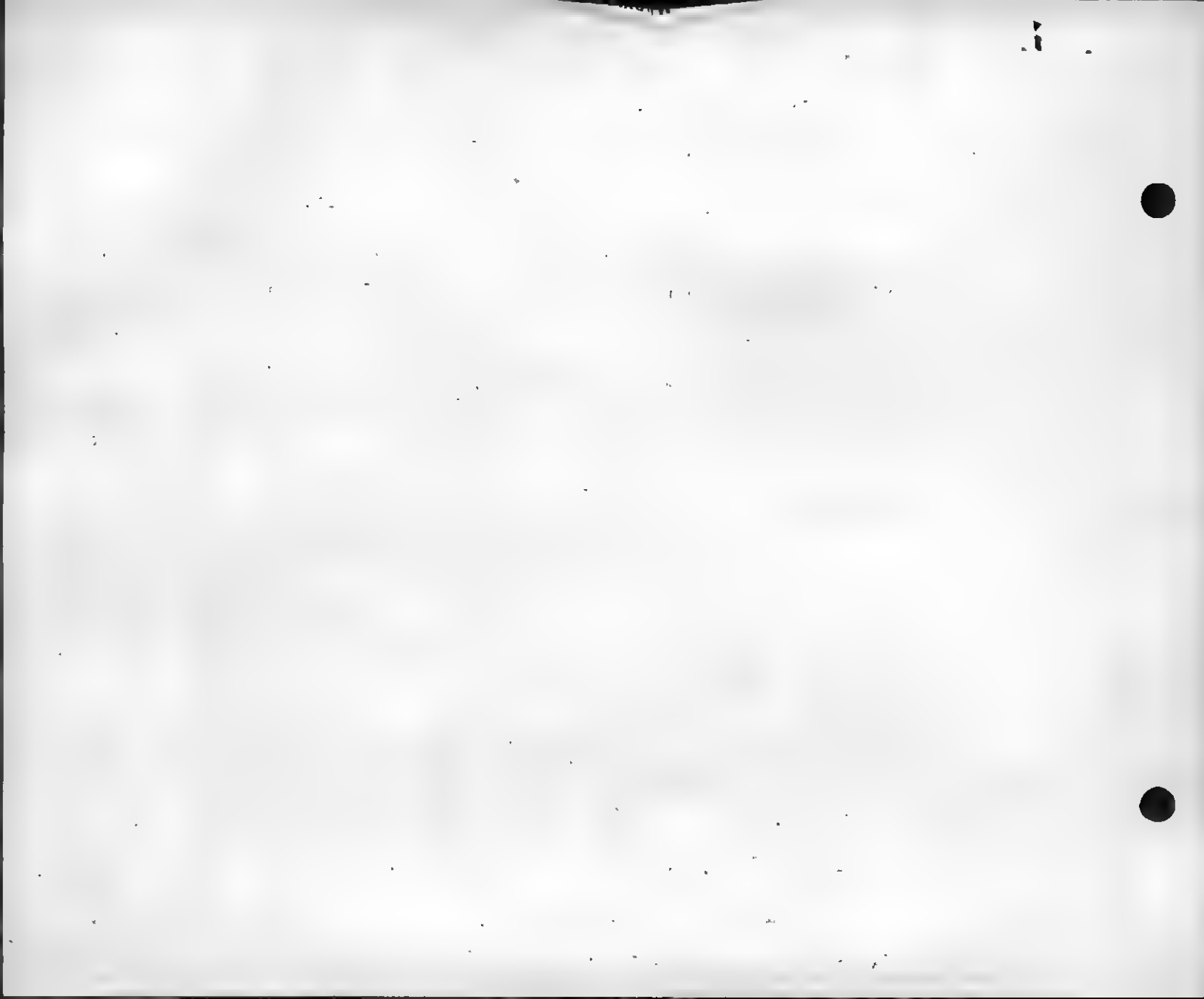


CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Charles Henry Mines			2a. DATE OF DEATH Month Day Year March 8 1968			2b. HOUR M. MIN. 12:02A	
3 SEX Male		4 RACE Negro		5 DATE OF BIRTH 9 July 1917		6 AGE (In years lost birthday) 50 YRS.	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN, OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
1d. CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Cement Finisher		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Virginia		13b. COUNTY Hanover		13c. CITY OR TOWN Dorsey		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER Route 1, Box 191		14. FATHER'S NAME First Middle Last Joshua --- Mines		15. MOTHER'S MAIDEN NAME First Middle Last Lillie --- Robinson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 227-18-4748		17 INFORMANT The Medical Records, Address The Clinical Center, Bethesda, Maryland 20014			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure 7-40 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Progressive systemic sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 1 1/2 Years							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 Months
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 34							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med co examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from 5 December, 1967, to 8 March, 1968, that (X) (we) last saw the deceased alive on 8 March 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Karl Engelman MD DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED 8 March 1968	
22d. PHYSICIAN'S NAME (Type) Karl Engelman, M. D.						22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3-14-68		23c. NAME OF CEMETERY OR CREMATORY FAMILY CEMETERY		23d. LOCATION (City or Town) (County) (State) HANOVER COUNTY, VA.	
24. FUNERAL DIRECTOR John T. Rhine Co. 305-12521 XE				25a. REC'D BY REGISTRAR DATE MAR 12 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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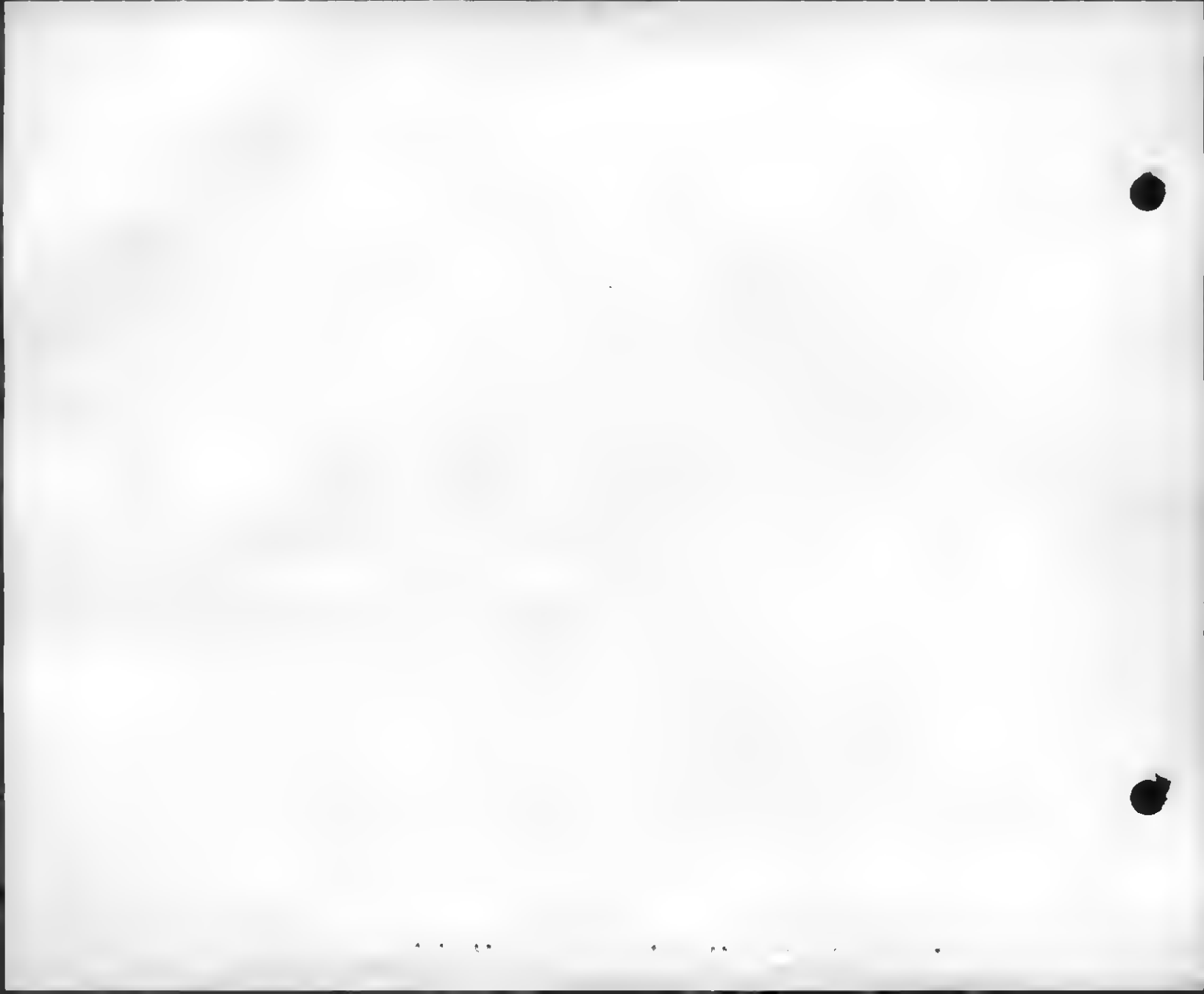


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <i>Eugenia</i> First Middle Last			2a. DATE OF DEATH Month <i>3</i> Day <i>26</i> Year <i>1968</i>			2b. HOUR <i>6:55</i> P. M.	
3. SEX <i>Female</i>		4. RACE <i>colored</i>		5. DATE OF BIRTH <i>2/19/1896</i>		6. AGE (In years lost birthday) <i>72</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>Blair, S.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md	
10. CITY OR TOWN OF DEATH <i>Wheaton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>University Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Diet Cook</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before adm syon) STATE <i>Washington, DC</i>		13b. COUNTY <i>✓</i>		13c. CITY OR TOWN <i>✓</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>500 4th St. N.W.</i>		14. FATHER'S NAME First Middle Last <i>unknown</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>unknown</i>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i> (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Conclusive heart failure</i> <i>412.9</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <i>1 month</i> <i>5 yrs.</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home farm street factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>3/22, 1968</i> , to <i>3/26, 1968</i> , that (I) (we) lost the deceased alive on <i>3/26, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Myron L. Larkin M.D.</i>				22c. DATE SIGNED <i>3/26/68</i>		22d. PHYSICIAN'S NAME (Type)	
22e. ADDRESS				22f. ADDRESS			
23a. BURIAL, CREMATION, REINTERMENT <i>Burial</i>		23b. DATE <i>3/30/1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lincoln</i>		23d. LOCATION (City or Town) (County) (State) <i>Suitland, Maryland</i>	
24. FUNERAL DIRECTOR <i>W. Ernest Jarvis Co., Inc.</i>				24b. ADDRESS <i>1432 You St., N.W.</i>		24c. REC'D BY REGISTRAR <i>Charles Judge</i>	
24d. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				24e. DATE <i>MAR 28 1968</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT.

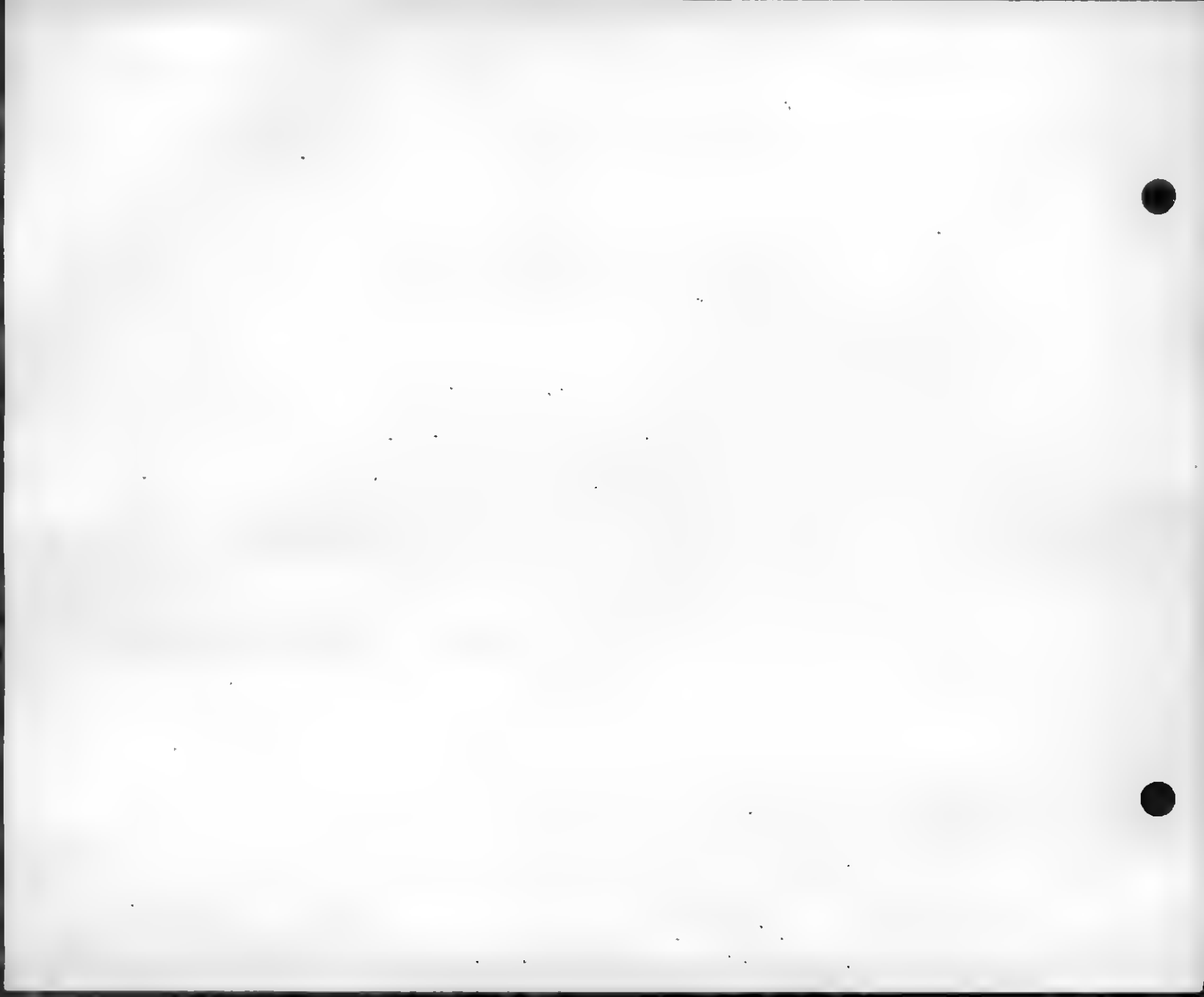
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) Samuel Herbert Mobley			2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> March 4 1968			2b HOUR 2:50 AM		
3 SEX male	4 RACE white	5. DATE OF BIRTH July 16, 1894	6 AGE (In years last birthday) 73 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS HOURS 0 MIN 0	2c DATE PRONOUNCED DEAD Month MAR Day 4 Year 68		2d HOUR 2:50 AM
7a BIRTHPLACE (State or foreign (or indy)) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md		
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Clarksburg		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER P.O. Box 62
14. FATHER'S NAME First Andrew Middle Jackson Last Mobley				15. MOTHER'S MAIDEN NAME First Harriett Middle Selby Last Selby				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		(If yes give war or dates of service) WW-I		16b SOCIAL SECURITY NO. 215-16-0180		17. INFORMANT (Last) Alvin Mobley ADDRESS Mt. Airy, Maryland		
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage - DUE TO, OR AS A CONSEQUENCE OF Conditions if any, which gave rise to immediate cause (a) stating the underlying cause last. Cardio Vascular Disease - (b) Cardio Vascular Disease - DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 hr. years.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a DATE OF OPERATION 3-7-68			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HO: R A M P M 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County State
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE John E. Ball MD				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED March 4, 1968		
EXAMINER'S NAME (Type) Ernest C. Gartner				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
ADDRESS (Street, city, town, or county) Clarksburg, Md.								
23a BURIAL, CREMATION REMOVAL (Specify) Burial		23b DATE 3-7-68		23c NAME OF CEMETERY OR CREMATORY Fourth Oak		23d LOCATION (City or Town) Clarksburg (County) Montg (State) MD		
24 FUNERAL DIRECTOR Ernest C. Gartner		ADDRESS Clarksburg, Md.		25a REC'D BY REGISTRAR Charles J. Jones		25b REGISTRAR'S SIGNATURE Charles J. Jones		



FOR STATE
HEALTH DEPT.

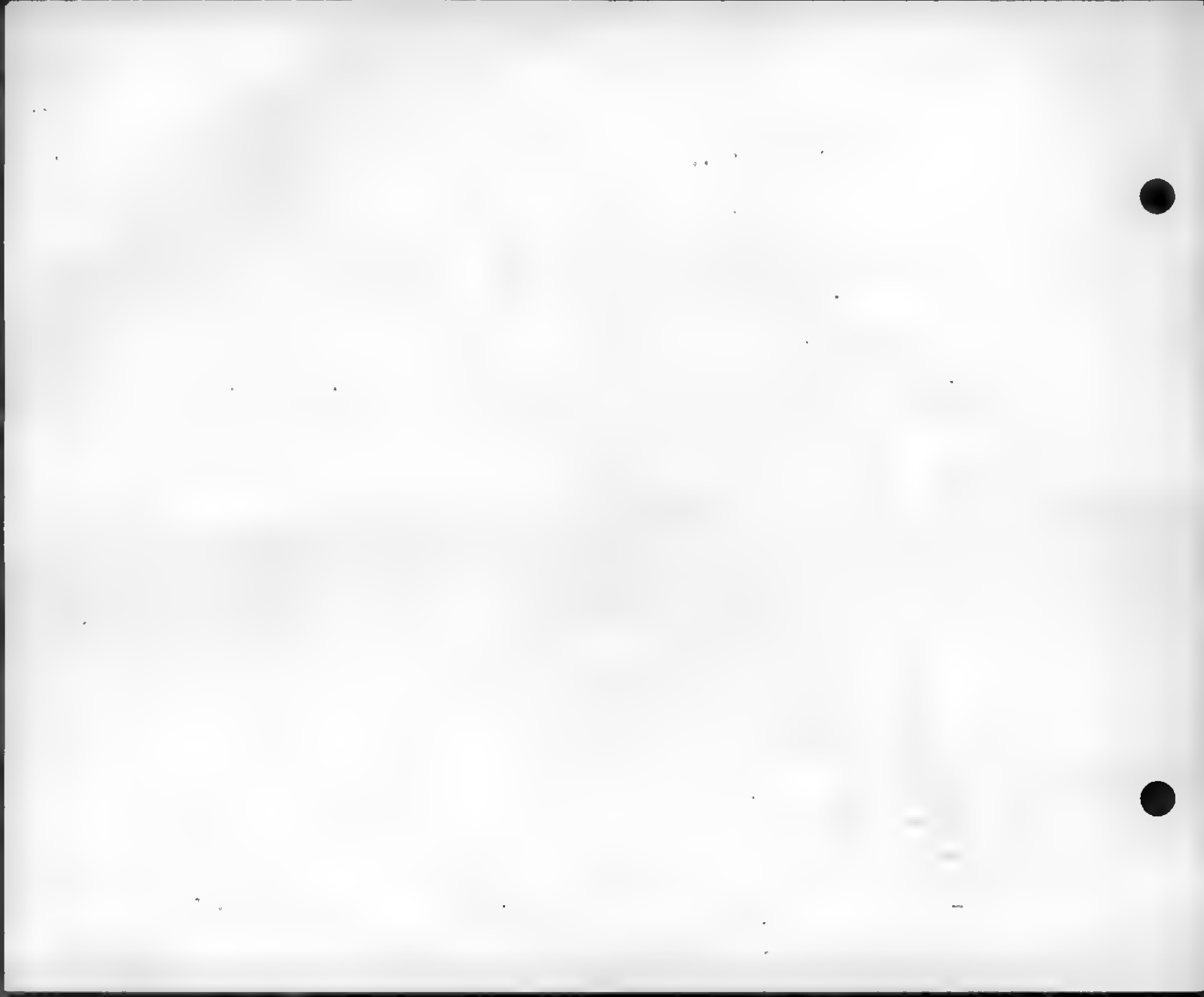
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

439.1

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year		2b HOUR
TED J MONTANO					MAR 17 1968		5:15 PM
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year	
MALE	CAUC	10 NOV. 1945	22 YRS			MARCH 17 1968 5:15 PM	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH	
		USA				MONTGOMERY Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY	
BETHESDA		NAVAL HOSPITAL		USMC		OC	
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
COL.				PUEBLO		2041 E 7th ST.	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO	
-DELLOY Deloy		MONTANO		Manuelita Gomez			
17 INFORMANT		ADDRESS		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DELLOY MONTANO		2041 E 7th ST.		PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>meningi coccoemia</u>		12 hr.	
				(b) <u>Waterhouse-Friderichsen Syndrome</u>			
				(c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
057.1							
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
		19					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		John G. Ball		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED	
EXAMINER'S NAME (Type)		John G. Ball, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		March 18, 1968	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ADDRESS (Street, city, town or county)			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
Rem-Burial		3/20/68		Roselawn Cemetery		Pueblo, Colorado	
24 FUNERAL DIRECTOR		Falls Church Funeral Home		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
1102 West Broad St., Falls Church, Virginia				MAR 21 1968		Charles J. Jones	

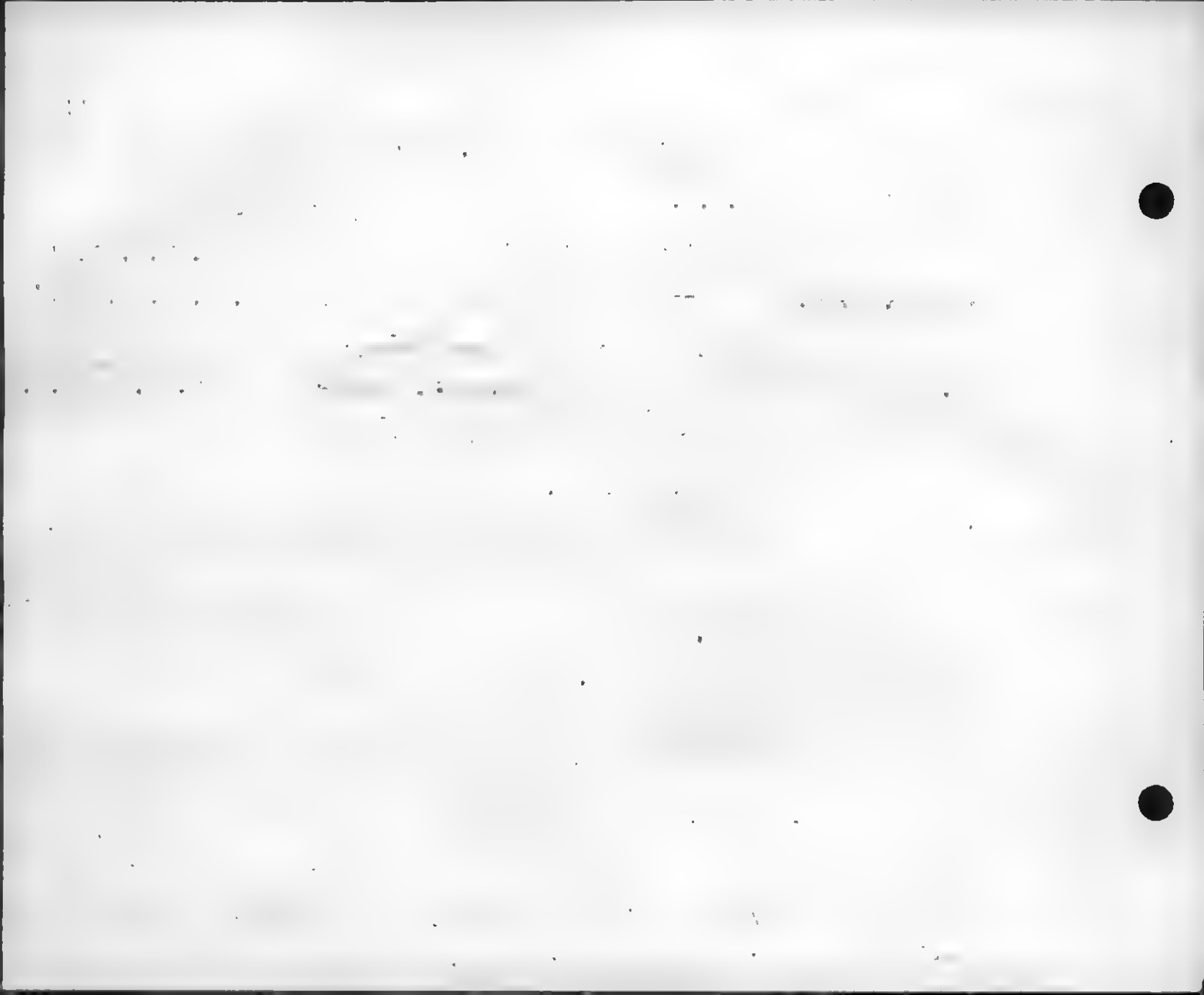


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First MARY Middle YOUNG Last MORRIS			2a. DATE OF DEATH Month 3 Day 16 Year 68		2b. HOUR 8:30 P M
3. SEX female	4. RACE white	5. DATE OF BIRTH Jan. 31, 1885		6. AGE (in years or birthday) 83 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0
7a. BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md		
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) University Nursing Home		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) Bureau of Eng. U.S. Gov't	
13a. USUA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Dist. NW.		13b. COUNTY --	13c. CITY OR TOWN DC Washington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1830 R. St. N. W. 52 Apt. 52
14. FATHER'S NAME First C Middle Preston Last Morris			15. MOTHER'S MAIDEN NAME First Mary Middle Young Last Young		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 162	17. INFORMANT Address Washington Sophia M. Morris 1830 R St. N.W. D.C.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural Hematoma 143X DUE TO, OR AS A CONSEQUENCE OF (b) Fall and injury to head DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 years 8 years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 162					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 1968 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 2/14 , 19 68 , to 3/16 , 19 68 , that (I) (we) last saw the deceased alive on 2/16 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Lewis A. Klein, M.D. DEGREE <input checked="" type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 3/16/68	
22d. PHYSICIAN'S NAME (Type) Lewis A. Klein				22e. ADDRESS 1319 HIGHLAND DRIVE, SILVER SPRING, MD	
23a. BURIAL, CREMAT., OR REMOVAL (Specify) Burial		23b. DATE 3/19/68		23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery	
23d. LOCATION (City or Town) Culpeper, Virginia		(County) Stafford		(State) Virginia	
24. FUNERAL DIRECTOR W. H. Hines Co. ADDRESS 2901 14th NW DC				25a. REC'D BY REGISTRAR DAMAR 19 1968	
				25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR STATE HEALTH DEPT

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Items 21, 22a film 399 MARYLAND STATE DEPARTMENT OF HEALTH
4-11-68 mt DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED NAME (Type or Print) <i>Rannie Oliver Morris</i>		First Middle Last		2a DATE KNOWN OF DEATH MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <i>Mar. 30 1968 3:30 P.M.</i>		2b HOUR	
3 SEX <i>m</i>	4 RACE <i>W</i>	5 DATE OF BIRTH <i>Feb. 25-57</i>	6 AGE (In years last birthday) <i>11</i> YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month <i>March</i> Day <i>30</i> Year <i>1968</i>	2d HOUR <i>3:30 P.M.</i>
7a BIRTHPLACE (State or foreign country) <i>Tanna</i>		7b CIT. ZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i> Md	
10 CITY OR TOWN OF DEATH <i>Richman</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Student</i>		12b KIND OF BUSINESS OR INDUSTRY	
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i> COUNTY <i>Montgomery</i>		13b CITY OR TOWN <i>Germantown</i>		3d INSIDE CITY Y.N. YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>RTE. 118</i>	
14 FATHER'S NAME First <i>Ellis Morris Jr.</i> Middle <i>Jr.</i> Last <i>Jr.</i>		15 MOTHER'S MAIDEN NAME First <i>Helen Mae</i> Middle <i>Ward</i> Last <i>Ward</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO <i>-</i>		17 INFORMANT ADDRESS <i>Helen Mae Ward same as above</i>			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Exsanguination</i> <i>12.29</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Gunshot Wound of Abdomen</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>1176</i>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year <i>1:15 P.M. 5-30 1968</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>deceased accidentally shot when brother tried to pick up load a rifle</i>			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>		21f LOCATION Street or R.F.D. No <i>Germantown</i> City or Town <i>Mont</i> County <i>Md</i> State			
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Belden R. Reap</i>		EXAMINER'S NAME (Type) <i>BELDEN R. REAP M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED <i>3/30/1968</i>	
23a BURIAL, CREMATION, REMOVA. (Specify) <i>Burial</i>		23b DATE <i>4-3-68</i>		23c NAME OF CEMETERY OR CREMATORY <i>Beth's Ch.</i>		23d LOCATION (City or Town) <i>Germantown</i> (County) <i>Montg.</i> (State) <i>Md.</i>	
24 FUNERAL DIRECTOR <i>Ernest E. Gartner</i>		ADDRESS <i>Faithersburg, Md.</i>		25a REC'D BY REG. STRAR <i>APR 3 1968</i>		25b REG. STRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) STUART WILSON MORRISSETTE			2a. DATE OF DEATH MARCH Month 20 Day 1968 Year		2b. HOUR 2:00 PM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH JANUARY 2, 1915		6. AGE (In years lost birthday) 53 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? AMERICAN U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY Md		
10. CITY OR TOWN OF DEATH TAKOMA PARK	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) WASHINGTON SANITARIUM Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CAB DRIVER	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND COUNTY PRINCE GEORGES	13b. CITY OR TOWN MT. RAINIER	13c. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 3117 QUEENS CHAPEL ROAD		
14. FATHER'S NAME First WHITT Middle MORRISSETTE Last UNKNOWN		15. MOTHER'S MAIDEN NAME First UNKNOWN Middle UNKNOWN Last UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 579033113	17. INFORMANT Alma S. Morrisette Address Same as #13.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Perforated duodenal ulcer					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 0001					
(b) PERITONITIS, C.H.F					
(c) Renal insufficiency					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month 18 Day 20 Year 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. 11200 Lockwood Dr. City or Town Silver Spring County Montgomery State Md	
22a. I certify that (I) (this hospital) attended the deceased from March 18, 1968 , to March 20, 1968 , that (I) (we) last saw the deceased alive on March 20, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Irady Sadeghian DEGREE M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED March 20, 1968
22d. PHYSICIAN'S NAME (Type) IRADJ SADEGHIAN M.D.		22e. ADDRESS 11200 Lockwood Dr. Silver Spring Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 24 Mar. 1968	23c. NAME OF CEMETERY OR CREMATORY LEBANON CEMETERY		23d. LOCATION (City or Town) (County) (State) RONCEVERTE, W. VIRGINIA	
24. FUNERAL DIRECTOR W. W. Chambers Co.		ADDRESS Riversdale, Md.		25a. REC'D BY REGISTRAR DATE MAR 27 1968	

185.4

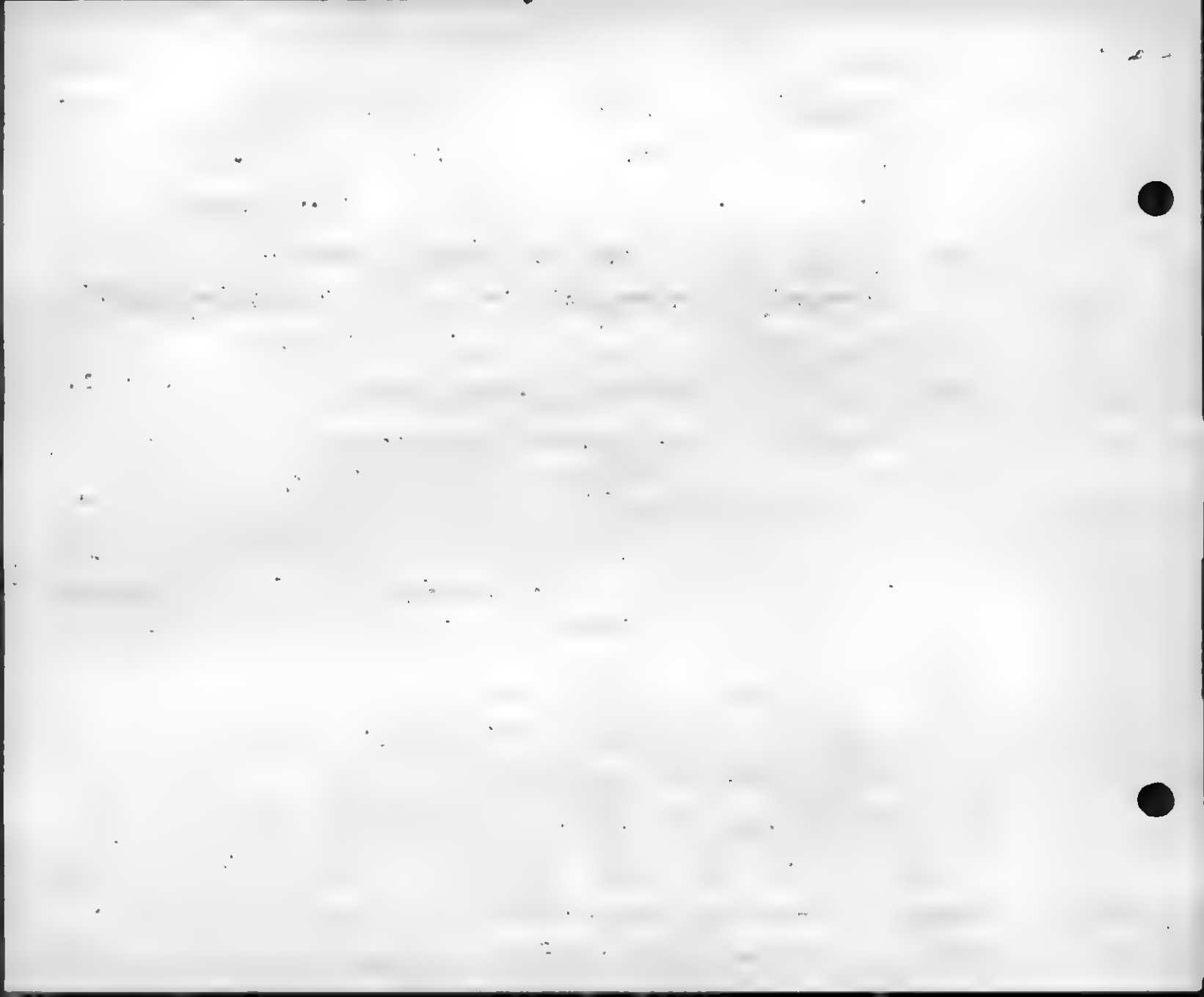
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last <i>Arthur F. Mundis</i>			2a. DATE OF DEATH Month Day Year <i>3 29 68</i>			2b. HOUR <i>1:45 A M</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>5-6-07</i>		6. AGE (In years lost birthday) <i>60 YRS.</i>	
7a. BIRTHPLACE (State or foreign country) <i>Penna.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross Hosp</i>		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) <i>Auditor</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>1111 University Blvd W</i>		14. FATHER'S NAME First Middle Last <i>Garfield C. Mundis</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Iva Peryl Snyder</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <i>No</i>		16b. SOCIAL SECURITY NO <i>Unknown</i>		17. INFORMANT <i>M. Beth Mundis</i>		Address <i>Same as Item 13.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hepatic failure</i> <i>5/11/68</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>5/10</i> (b) <i>Embolism of liver</i> DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>several yrs</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>① Splenectomy for hypersplenism ② Acute renal failure recovered</i>							
19a. DATE OF OPERATION <i>3/15/68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>2° Hypersplenism</i>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes.</i>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>March 13, 1968</i> , to <i>March 21, 1968</i> , that (I) (we) last saw the deceased alive on <i>March 21, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>H. F. Marcus MD</i>		DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>3-29-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Wm. Y. Marcus</i>		22e. ADDRESS <i>1620 Georgia Ave. S.E. Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4-1-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Resurrection Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Harrisburg, Penna.</i>	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>				25a. REC'D BY REGISTRAR <i>DATE APR 3 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04404

1 DECEASED-NAME (Type or print) XXXXXXXXXXXXXXX Thais Victoria Murphy		2a DATE OF DEATH 3 Month 4 Day 1968		2b. HOUR 9 40 PM	
3. SEX F		4. RACE W		5. DATE OF BIRTH APRIL 3 1891	
6. AGE (in years lost birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country) MARTINSBURG, W. VA.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 COUNTY OF DEATH MONTGOMERY		10. CITY OR TOWN OF DEATH SILVER SPRING, MD.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS HOSPITAL	
12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BETHESDA	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 9912 HARROGATE RD.			
14. FATHER'S NAME JAMES FITZGERALD		15. MOTHER'S MAIDEN NAME First FLORENCE		Middle VICTORIA	
Last HOYLE		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. _____	
17. INFORMANT Richard J. Murphy, Son		Address See item # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> + <u>ill</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Chronic bronchitis</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>5021</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u> <u>years</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Hypertensive arteriosclerosis cardiovascular renal disease</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	
21f. LOCATION Street or R.F.D. No. City or Town County State		22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1956</u> to <u>3-24-68</u> , that (I) (we) last saw the deceased alive on <u>3-24-68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Jason G. Giger, M.D.</u>	
22c. DATE SIGNED 3-24-68		22d. PHYSICIAN'S NAME (Type) Jason G. Giger, M.D.		22e. ADDRESS 800 <u>Washington Drive</u> <u>Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 3-28-1968		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		24. FUNERAL DIRECTOR Joseph Gawler Sons, Inc. 5130-Wisconsin Ave. N.W.		25a. REC'D BY REGISTRAR DATE APR 1 1968	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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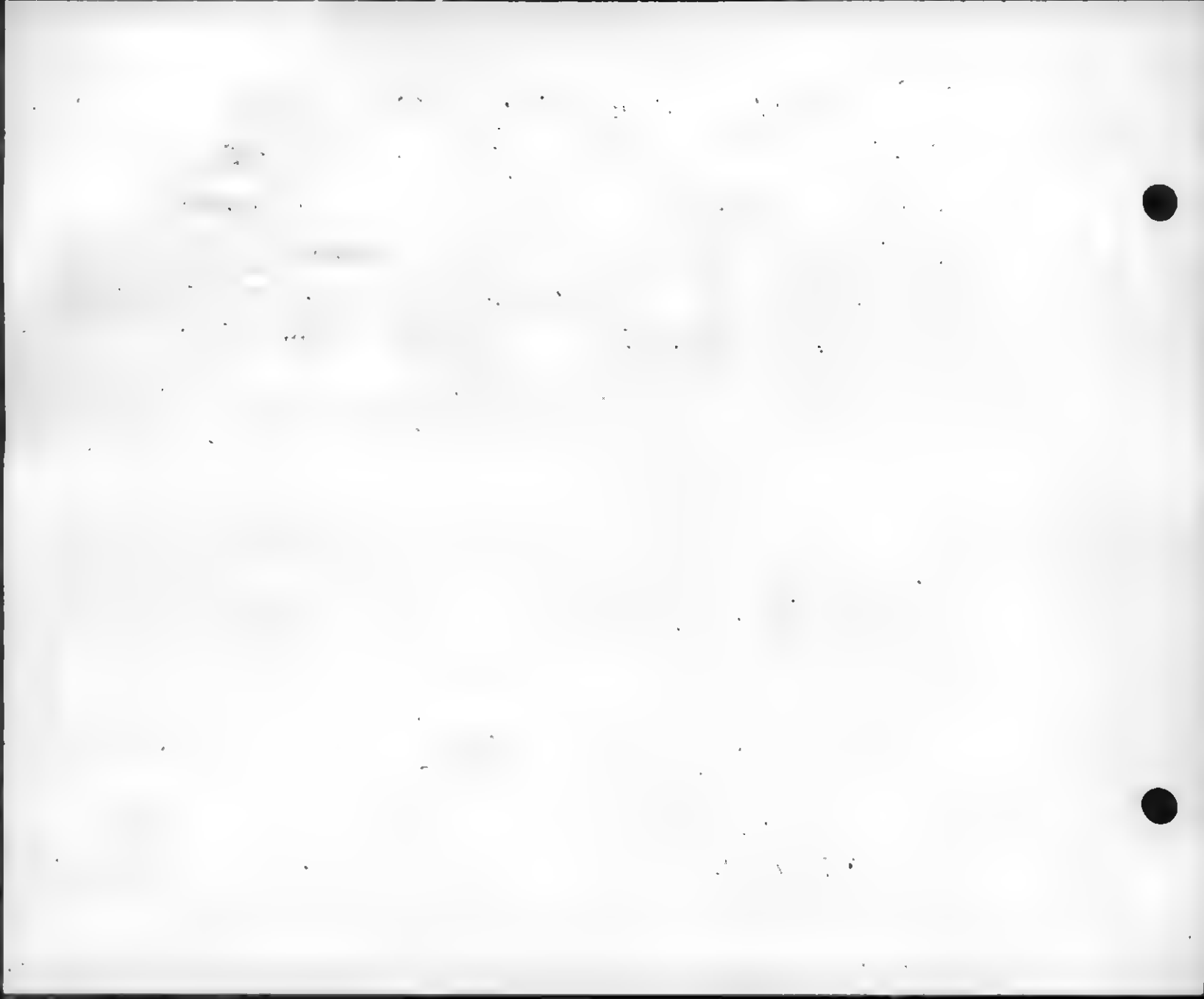
VR A15 (4)
304A REV 1/68

MD 4415

14415

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) WOLODYMIR First (NONE) Middle MALYWAJKO Last		2a. DATE OF DEATH Month MARCH Day 10 Year '68 2b. HOUR 12:15P	
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH APRIL 16, 1889	6. AGE (In years) lost birth 78 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) UKRAINE	7b. CITIZEN OF WHAT COUNTRY? "STATELESS"	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Colonial Villa Nurs. Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) LAWYER	12b. KIND OF BUSINESS OR INDUSTRY LAW
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD.	13b. COUNTY Prince George's	13c. CITY OR TOWN College Park	13d. INSIDE CITY (A.M. 1st) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET AND NUMBER 9207 Limestone Place
14. FATHER'S NAME First JULIAN Middle (NONE) Last MALYWAJKO	15. MOTHER'S MAIDEN NAME First Emilia Middle Sobko Last (last)	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO. 203-26-3595		17. INFORMANT daughter Mrs. Bondanna Golota Address SAME	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, 2° Carcinoma Kidney 1890 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. X (b) — DUE TO, OR AS A CONSEQUENCE OF (c) —			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs. ±
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Bleeding Peptic ulcer			
19a. DATE OF OPERATION 1965	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca. Kidney (Nematoma)	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) —	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) —	21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1960 , 19 — , to 3/10, 1968 , that (I) (we) last saw the deceased alive on 3/19, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			
22b. SIGNATURE J. Frederick Barr MD		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 3/10/68
22d. PHYSICIAN'S NAME (Type) J. FREDERICK BARR, M.D.		22e. ADDRESS 4500 College Ave., College Park, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/14/68	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Washington, D.C.
24. FUNERAL DIRECTOR The S. H. Hines Company		ADDRESS Washington, DC	25a. REC'D BY REGISTRAR DATE MAR 13 1968
		25b. REGISTRAR'S SIGNATURE Charles Judge	



Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
30M REV. 1/68

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) MARY		First M.		Middle N.		Last NEEL		2a. DATE OF DEATH Month March Day 2 Year 1968		2b. HOUR 3:30 PM	
3. SEX Female		4. RACE white		5. DATE OF BIRTH 8/25/06		6. AGE (In years last birthday) 61 YRS.		7. IF UNDER 1 YEAR MONTHS 6 DAYS 1		7. IF UNDER 24 HRS HOURS 3 MIN 30	
7a. BIRTHPLACE (State or foreign country) Ill.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Randolph Hills Nursing Home		2a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE MD.		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4311 Fernhill Rd.			
14. FATHER'S NAME First James Middle Rubert Last NEEL		15. MOTHER'S M.A.D.E.N. NAME First Ellen Middle Serphast Last NEEL		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 220-28-5615		17. INFORMANT Nursing Home Records - 4311 Fernhill Rd.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Glioblastoma Multiforme 191X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mo.		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year 19 P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____		22a. I certify that (I) (this hospital) attended the deceased from 12/24/1967 , to 3/2/1968 , that (I) (we) lost the deceased alive on 2/24/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert C. Macor		DEGREE _____		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/2/68					
22d. PHYSICIAN'S NAME (Type) Robert C. Macor		22e. ADDRESS 809 Viers Mill Rd., Rockville, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) 3/5/68		23b. DATE 3/5/68		23c. NAME OF CEMETERY OR CREMATORY Montgomery		23d. LOCATION (City or Town) (County) (State) Rockville, Md.					
24. FUNERAL DIRECTOR William C. Hill		ADDRESS Barnesville Rd.		25a. REC'D BY REGISTRAR MAR 7 1968		25b. REGISTRAR'S SIGNATURE William C. Hill					



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, marking the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) William Gordon			First Middle Last			2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> March 29 1968 3:24 P			2b HOUR		
3 SEX Male	4 RACE Caucasian	5 DATE OF BIRTH 11 May 1911	6 AGE (In years last birthday) 56 YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD Month Day Year March 29 1968 3:24 P			2d HOUR
7a BIRTHPLACE (State or foreign country) Delaware		7b CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery			Md		
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital, Bethesda			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Law Officer			12b KIND OF BUSINESS OR INDUSTRY U.S. NAVY		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE N.Y.			13b. COUNTY Levittown		13c. CITY OR TOWN Levittown		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 32 Old Hill Lane		
14. FATHER'S NAME Clarence Given NEESE			First Middle Last			15 MOTHER'S MAIDEN NAME Flossie A. STRAW			First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES			16b. SOCIAL SECURITY NO MAR 43-MAR 68 067-07-9652			17 INFORMANT Mrs. Edith Boyd NEESE RT. #2, Box 288,			ADDRESS Arnold, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Aneurysm											
DUE TO, OR AS A CONSEQUENCE OF (b) Rupture of Dissecting Aneurysm											
DUE TO, OR AS A CONSEQUENCE OF (c) of Aorta with Eysanguination											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 451 X											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A M P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Belden R. Reap			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 3/30/1968		
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, City, Town or County) Washington					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4/2/68		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem.			23d. LOCATION (City or Town) (County) (State) Arlington, Virginia			
24. FUNERAL DIRECTOR Falls Church F.H., Falls Church, Va.						25a. REC'D BY REGISTRAR DATE APR 2 - 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		



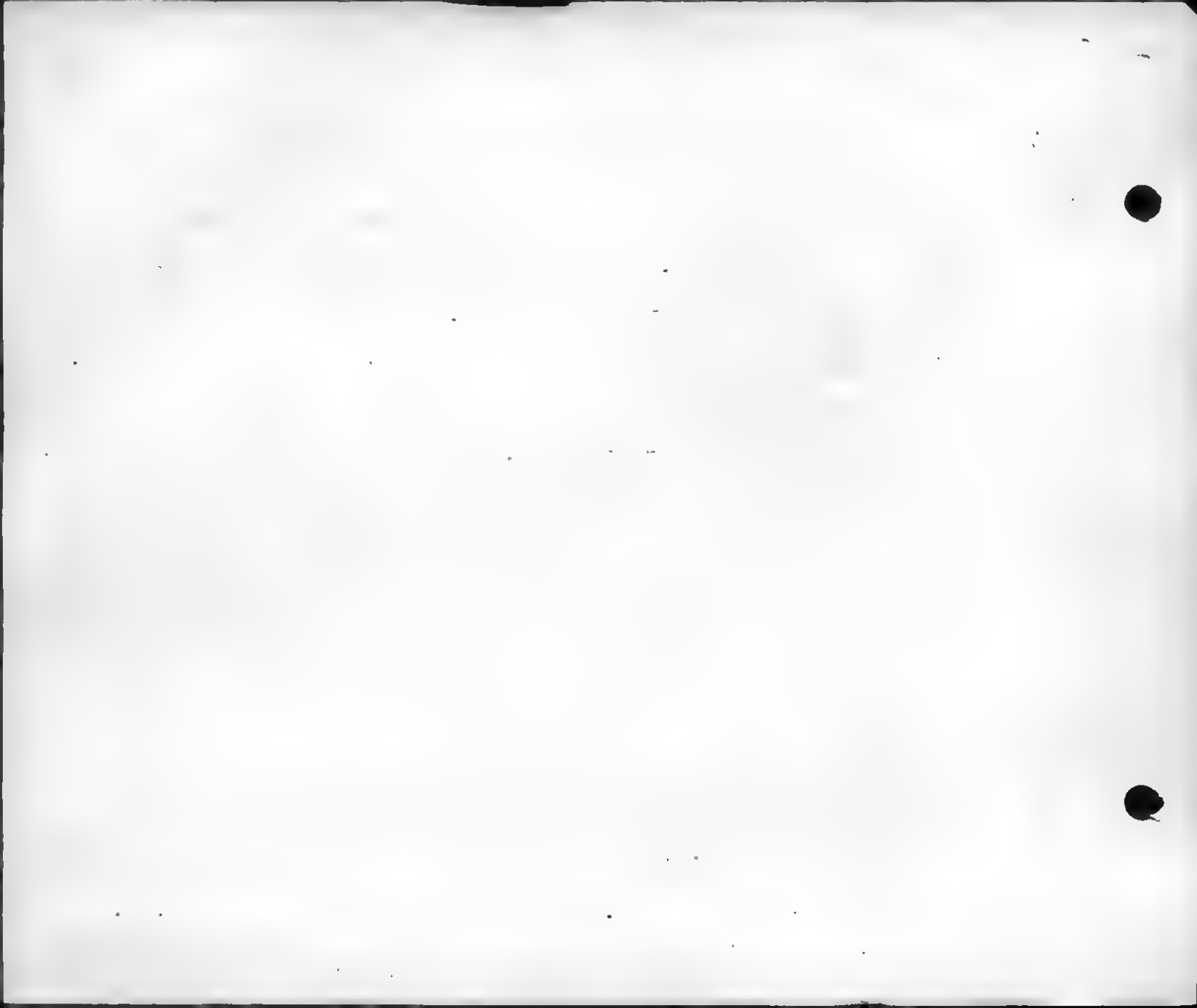
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4401 East West Highway		d. STREET ADDRESS 4401 East West Highway	
3. NAME OF DECEASED (Type or print) First Middle Last HELEN L. O'DONNELL		4. DATE OF DEATH Month Day Year Mar. 31, 1968	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 6, 1874
9. AGE (In years last birthday) 93 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Penna.
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Patrick Charles	
14. MOTHER'S MAIDEN NAME Ellen (Unknown)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 415-54-5163		17. INFORMANT Son J. Joseph O'Donnell - Arlington, Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia 401X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Terminal DUE TO (c) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus; Essential Hypertension		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 1953 to March 30, 1968 , that (I) (we) last saw the deceased alive on March 30, 1968 , and that death occurred at 4:45 PM , from causes and on the date stated above			
22a. SIGNATURE Bertram F. Schaefer M.D.		22b. DATE SIGNED 3/31/68	
22c. PHYSICIAN'S NAME (Type) BERTRAM F. SCHAEFER		22d. ADDRESS 1780 Man. Ave. NW. Wash. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-2-68	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Washington, D. C.
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. RECD BY REGISTRAR APR 3 - 1968	25b. REGISTRAR'S SIGNATURE Charles Judge

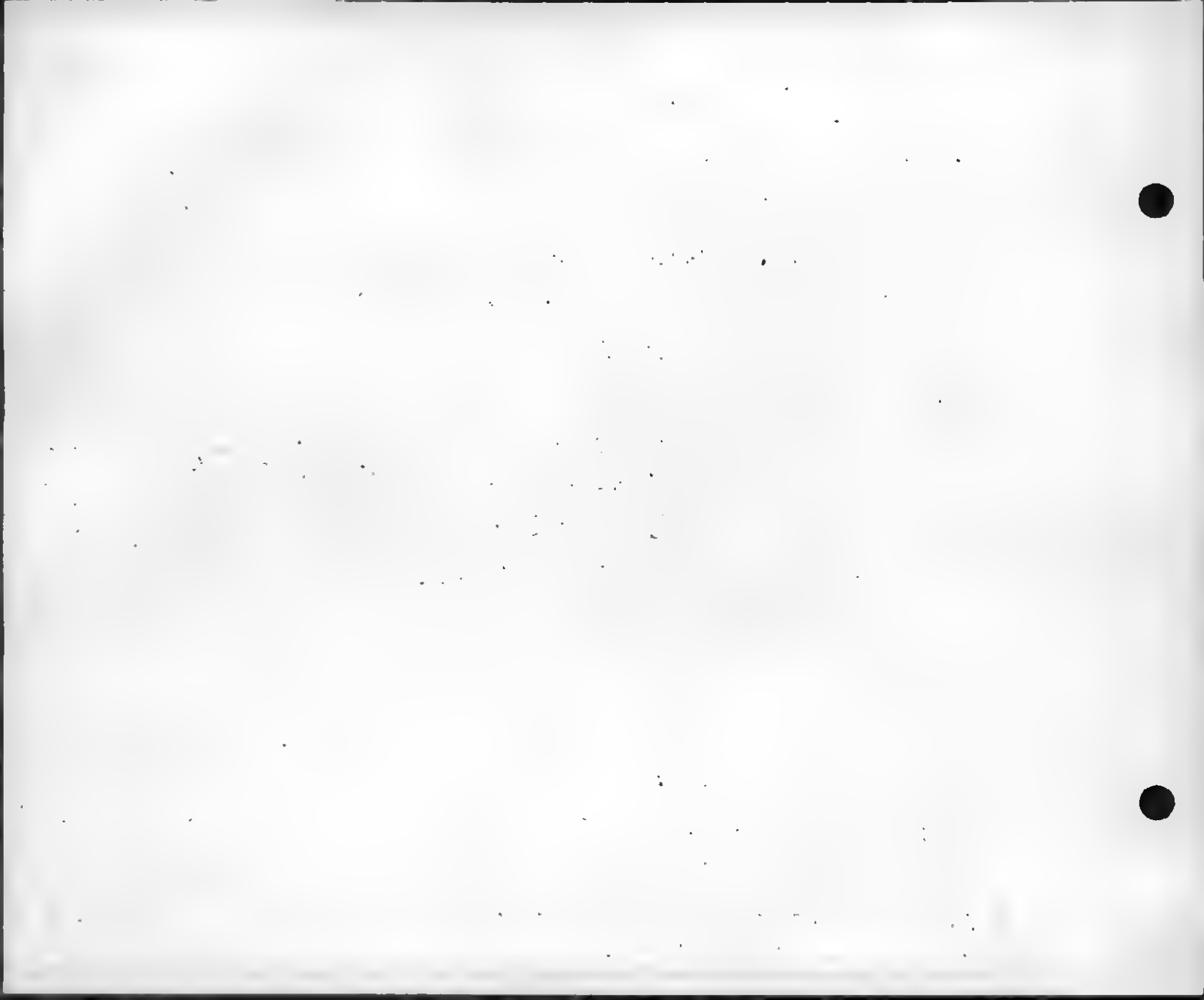


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) ELIZA ELIZABETH OSBORNE			2a. DATE OF DEATH Month MARCH Day 25 Year 1968			2b. HOUR 4:32 M PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 6-13-93		6. AGE (In years last birthday) 74 YRS. 9 MONTHS 12 DAYS	
7a. BIRTHPLACE (State or foreign country) TENN.		7b. CITIZEN OF WHAT COUNTRY? AMERICAN		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md	
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASH. SAN. & Hosp.		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) HOUSE KEEPER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY CLARKSVILLE		13c. CITY OR TOWN CLARKSVILLE YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First MARION Middle GENTRY Last ELVIA		15. MOTHER'S MAIDEN NAME First ELVIA Middle GILBERT Last GILBERT					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 214-68-1991		17. INFORMANT CHART Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia + progressive DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus Approximate interval between onset and death: 7-10 days years years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (to) Hypertension + arteriosclerosis heart disease							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home farm street factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Dec 3-25-1967 , to March 25, 1968 , that (I) (we) last saw the deceased alive on 3-25-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John R. Spencer MD DEGREE MD				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-25-68	
22d. (PHYSICIAN'S NAME) (Type) John R. Spencer				22e. ADDRESS BURTONSVILLE, MD.			
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial		23b. DATE 3-28-68		23c. NAME OF CEMETERY OR CREMATORY Lake View Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Liberty Dam Carroll. Md	
24. FUNERAL DIRECTOR 316 E. Dignity Ave ADDRESS Baltimore, Md. 21202				25a. REC'D BY REGISTRAR DATE APR 27 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



Page 4 may be retained by the hospital or attending physician.

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24 MINERAL DIRECTOR

15. 00

DECEASED NAME (Type or print) JANIE		First JUNES		Middle OSTEEN		Last		20. DATE OF DEATH Month Mar. Day 4 Year 1968		26. HOUR 2:55 AM	
3. SEX Female		4. RACE white		5. DATE OF BIRTH 6-29-96		6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 12217 Berry St.			
14. FATHER'S NAME First Charles Middle Henry Last JONES				15. MOTHER'S MAIDEN NAME First Mary Middle Elizabeth Last McDuffie							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 2K3-12-5702		17. INFORMANT Charles J. Osteen - son - 4th name							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Infarction Multiple DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Jan 9 1968 Unknown										PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) Chronic Emphysema	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 3 March 1968 , 19 66 , to 4 Mar 1968 , that (I) (we) last saw the deceased alive on 3 March 1968 , and that in (my) (our) opinion death occurred on the date and hour noted from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE George Sharpe				22c. DATE SIGNED 4 Mar 68		22d. PHYSICIAN'S NAME (Type) George Sharpe		22e. ADDRESS 10400 Conn Avenue, Kensington, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/6/68		23c. NAME OF CEMETERY OR CREMATORY Willowdale Cemetery		23d. LOCATION (City or Town) (County) (State) Goldsborough, North Carolina					
24. NON-REGISTRAR C. Glen Carter		24a. ADDRESS 8434 Georgia Ave. Silver Spring, Md.		25a. REC'D BY REGISTRAR MAR 8 1968		25b. REGISTRAR'S SIGNATURE James J. Jones					

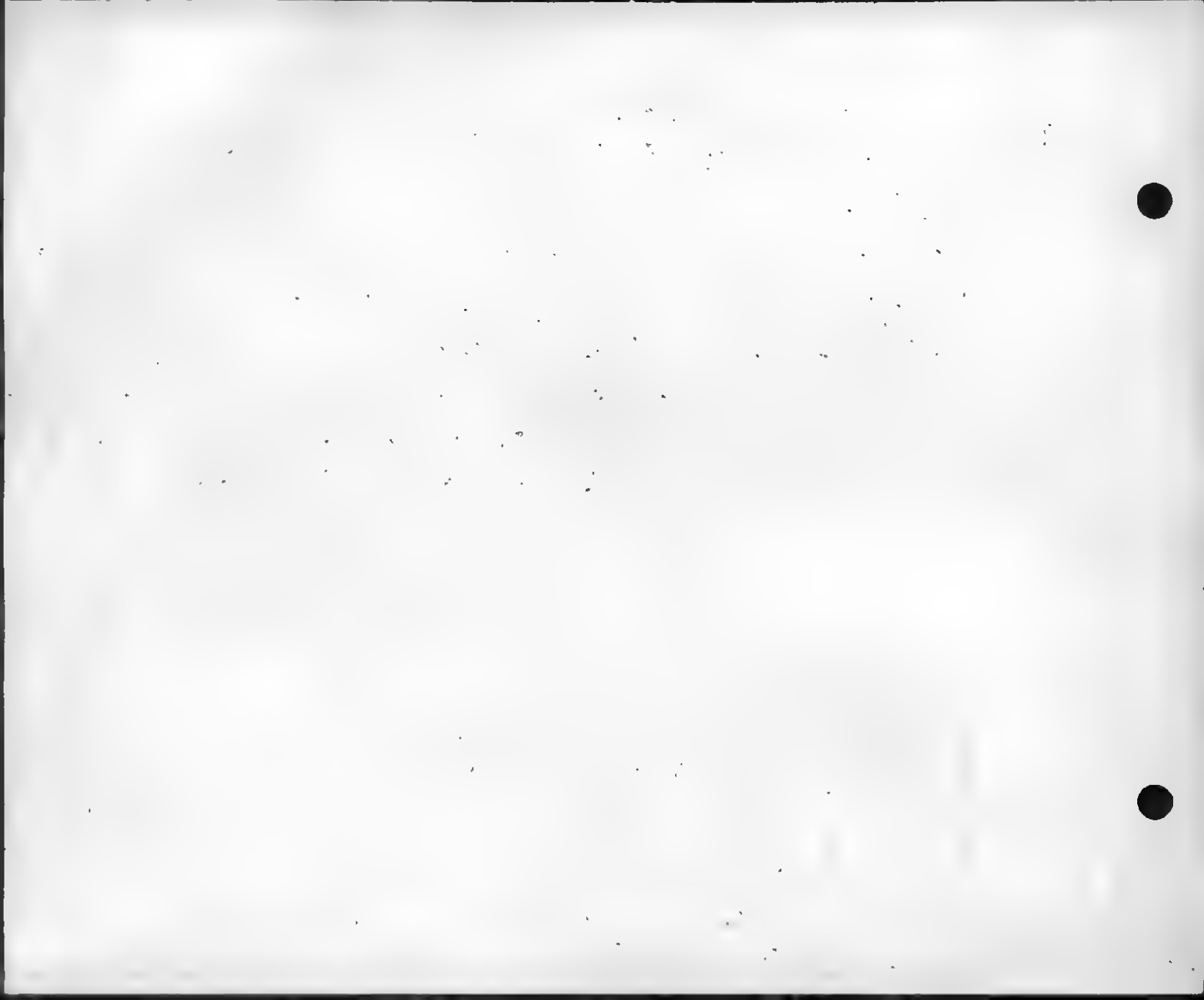


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

24
MAY 24 1968
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <i>Grafton Verby Page</i>			2a. DATE OF DEATH Month <i>March</i> Day <i>29</i> Year <i>1968</i>			2b. HOUR <i>6 p.m.</i>	
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>Oct 13, 1883</i>		6. AGE (In years) <i>84 yrs</i>	
7a. BIRTHPLACE (State or foreign country) <i>District of Columbia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md	
10. CITY OR TOWN OF DEATH <i>Olney</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Brooke Grove Foundation</i>			12a. LSUA. OCCUPATION (Kind of work done during most of working life, even if retired.) <i>U.S. Post Office</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Sandy Spring</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <i>1740 Norwood Rd.</i>		14. FATHER'S NAME First Middle Last <i>Harvey Linsley Page</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Urbabelle Ogden</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	
16b. SOCIAL SECURITY NO <i>012-24-81397</i>		17. INFORMANT <i>Page</i>		Address <i>1740 Norwood Rd. Sandy Spring</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4179</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Bronchopneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <i>Atherosclerotic Heart Disease</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sharp</i> <i>Yes</i>		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4179</i>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21c. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>1/16, 1968</i> to <i>3/29, 1968</i> , that (I) (we) last saw the deceased alive on <i>3/23, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.		22b. SIGNATURE <i>C. H. Higon</i>		22c. DATE SIGNED <i>3/29/68</i>		22d. PHYSICIAN'S NAME (Type) <i>C. H. Higon MD</i>	
22e. ADDRESS <i>Sandy Spring Md</i>		23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>March 30, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Port Lincoln Crematory</i>	
23d. LOCATION (City or Town) (County) (State) <i>Prince Georges Maryland</i>		24. FUNERAL DIRECTOR <i>Clark S. Pumphrey Inc. 8434</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH																			
1. DECEASED NAME (Type or Print)			First Grace		Middle Electa		Last Parker		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year 3/12 1968		2b. HOUR 10 PM								
3 SEX Female		4 RACE White		5. DATE OF BIRTH Nov. 17, 1875		6. AGE (In years less birthday) 92 YRS		7. UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year March 12 1968		2d. HOUR 10 PM					
7a. BIRTHPLACE (State or foreign country) Michigan				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Montgomery							
10. CITY OR TOWN OF DEATH Kensington				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kensington Gardens				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Librarian				12b. KIND OF BUSINESS OR INDUSTRY Library							
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE Michigan				13b. COUNTY Royal Oak				13c. CITY OR TOWN Royal Oak				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER 1527 Crooks Road			
14. FATHER'S NAME First Middle Last Ralzemond Allan Parker				15. MOTHER'S MAIDEN NAME First Middle Last Sarah Drake				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16b. SOCIAL SECURITY NO. 382-54-0299 J				17. INFORMANT Mr. Ralzemond P. Parker			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis. 4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular Disease - DUE TO, OR AS A CONSEQUENCE OF (c) years.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 months															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4222:																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE John G. Ball				EXAMINER'S NAME (Type) John G. Ball				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)				22b. DATE SIGNED March 13, 1968							
23a. BURIAL CREMATION, REMOVAL (Specify) Burial				23b. DATE March 16, 1968				23c. NAME OF CEMETERY OR CREMATORY Royal Oak Cemetery				23d. LOCATION (City or Town) (County) (State) Royal Oak, Michigan							
24. CEMETERY DIRECTOR Warner E. Pumphrey, Inc.				25. CEMETERY ADDRESS C. Glen Carter 80345 Georgia Ave				25a. REC'D BY REGISTRAR MAR 20 1968				25b. REGISTRAR'S SIGNATURE Charles Judge							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

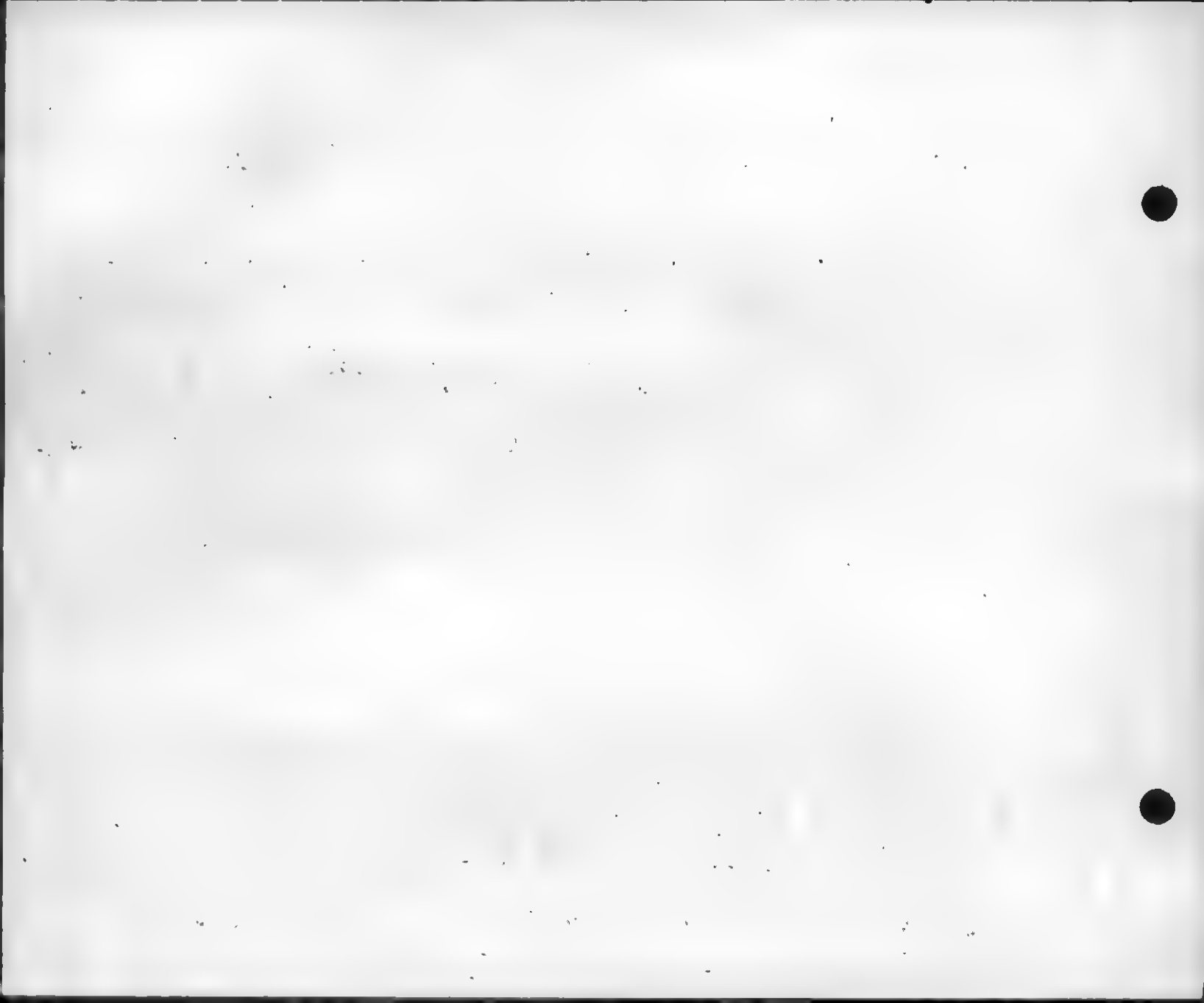
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MD 26
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last Marvin Ralph Payne			2a DATE OF DEATH Month Day Year March 17 68			2b HOUR 10:46 PM	
3 SEX male		4 RACE white		5 DATE OF BIRTH 12-3-1911		6 AGE (In years last birthday) 56.5 YRS.	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md	
10 CITY OR TOWN OF DEATH Takoma Park		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium & Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) Auditor - Govern		12b KIND OF BUSINESS OR INDUSTRY Fed. Gov't	
13a USUAL RESIDENCE (Where deceased lived, if not at an residence before admission) STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Silver Spring		13d INSIDE CITY LIM <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 401 Stonington Road		14 FATHER'S NAME First Middle Last Gibson S Payne		15 MOTHER'S MAIDEN NAME First Middle Last Mattie Kines			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b SOCIAL SECURITY NO (If yes give war or dates of service) 215-44-3442		17 INFORMANT LUCIE PAYNE Records - Washington Sanitarium & Hospital		Address P.O. Rd. P.O. Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Leukemia DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from November, 1967 to January, 1968, that (I) (we) lost the deceased alive on March 17, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE James W. Whitlock				22c DATE SIGNED 3-18-68			
22d PHYSICIAN'S NAME (Type) James W. Whitlock				22e ADDRESS 7717 Canall Ave Takoma Park Md			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE March 20, 1968		23c NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d LOCATION (City or Town) (County) (State) Rockville, Maryland	
24 FUNERAL DIRECTOR Glen Carter Wanner S. Pumphrey, Inc.				25a. REC'D BY REGISTRAR DATE MAR 21 1968		25b REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

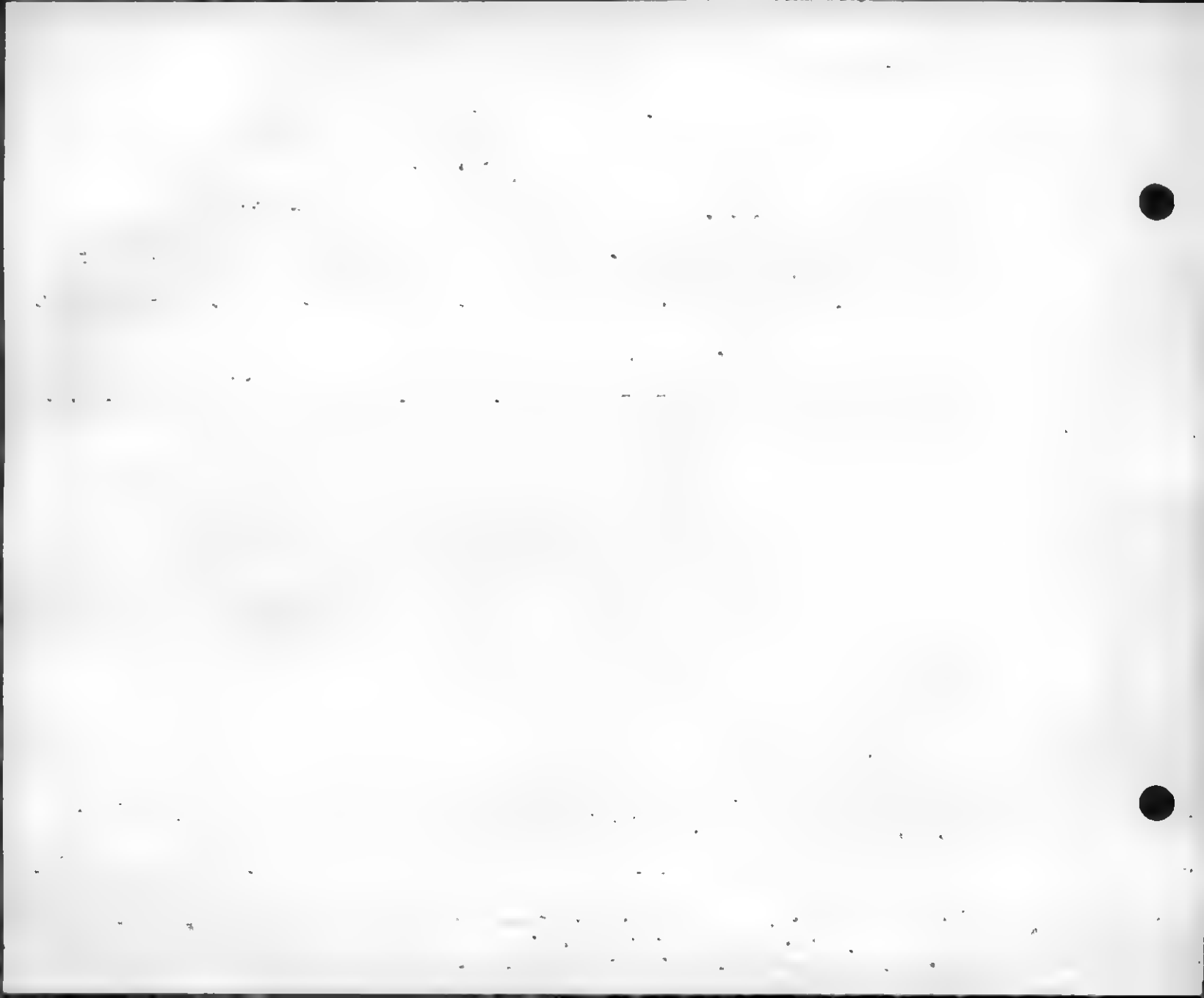


Item 18 fill in 3-2-68 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Clayton A. Phelps			2a. DATE OF DEATH Month March Day 6 Year 1968		2b. HOUR M
3 SEX Male	4. RACE White	5. DATE OF BIRTH Feb. 16, 1919		6 AGE (in years last birthday) 49 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery Md.		
10 CITY OR TOWN OF DEATH Silver Spring	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Mechanic	12b. KIND OF BUSINESS OR INDUSTRY Automobile		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spr.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 12,007 St. Dunston Lndr.	
14 FATHER'S NAME First Middle Last George B. Phelps	15 MOTHER'S MAIDEN NAME First Middle Last Antimesia King				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes (If yes give year or dates of service) WW II	16b. SOCIAL SECURITY NO. 217-18-3668	17 INFORMANT Address Mrs. Mary L. Phelps 12007 St. Dunston La. S.S., Md.			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 390X DUE TO, OR AS A CONSEQUENCE OF as associated with Cardiomegaly, Mitral (b) Insufficiency, Ruptured Chordae DUE TO, OR AS A CONSEQUENCE OF (c) Tendinae due to Rheumatic Fever Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. natural causes					
22b. SIGNATURE Belden R. Reap M.D.		22c. PHYSICIAN'S NAME (Type) Belden R. Reap M.D.	22d. ADDRESS 11502 Grandview Dr. Silver Spring, Md.	22e. DATE SIGNED 3/8/1968	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/9/68	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery	23d. LOCATION (City or Town) (County) (State) Silver Spring Mont. Maryland		
24. FUNERAL DIRECTOR C. Glen Carter Warner E. Pumphrey Inc. 8434 Georgia Ave. S.S.		25a. REC'D BY REGISTRAR MAR 11 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled up by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

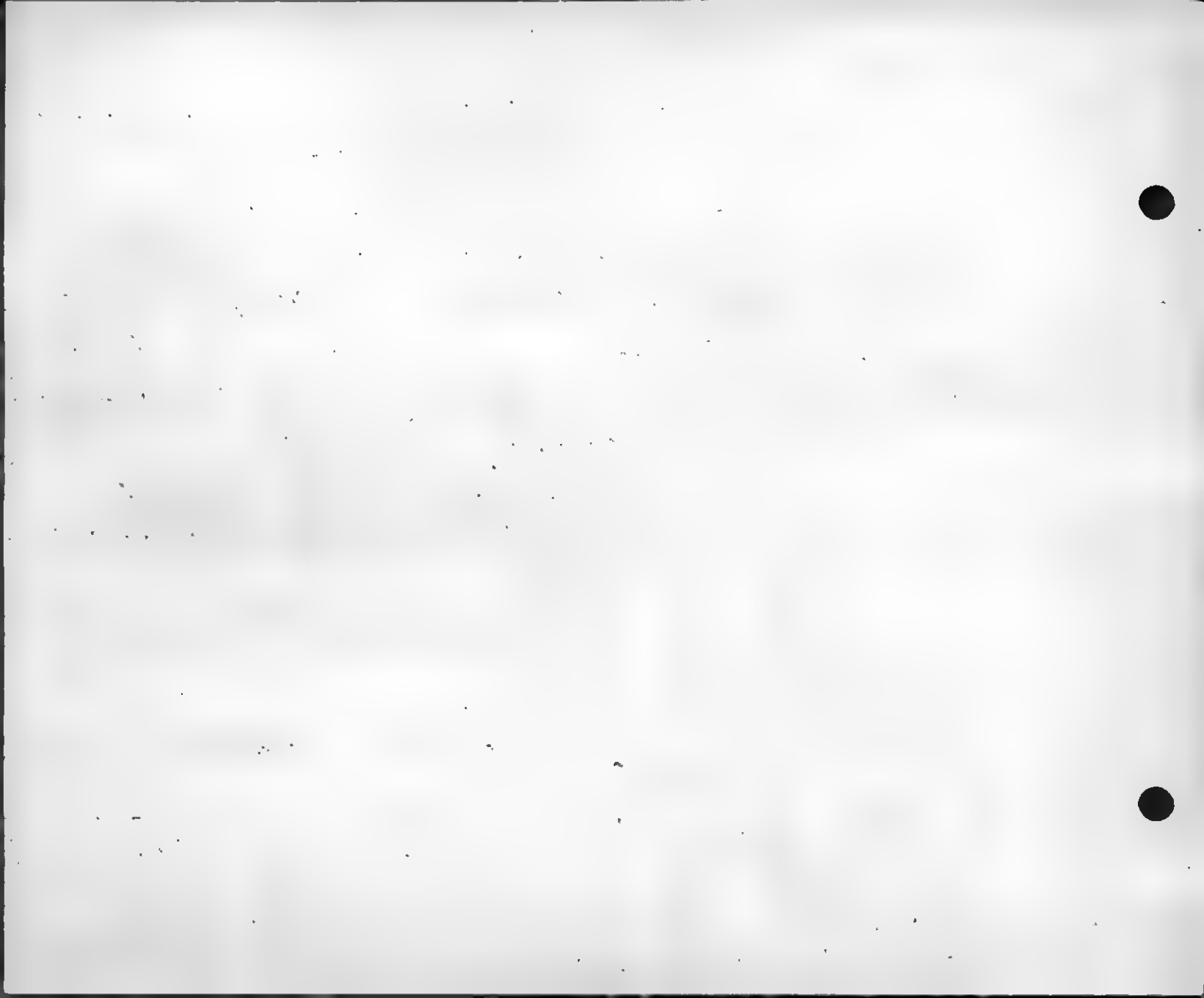


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last FLORENCE M PIERCE			2a. DATE OF DEATH Month Day Year March 30 1968			2b. HOUR 3:30 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH August 20-1884		6. AGE (In years lost birthday) 83 YRS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Kensington-			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kensington Gardens Sanitarium			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Clerk.	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Washington DC		13d. INSIDE CITY LIM. 1ST YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 1601 Argonne Place N.W.		14. FATHER'S NAME First Middle Last Louis Lamott Pierce		15. MOTHER'S MAIDEN NAME First Middle Last Frances Cross			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 578-48-0617		17. INFORMANT Frances A. Ambursen, 4712 Merivale Rd. C.C.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerotic Heart Disease 12 years</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arterio sclerosis & Hypertension 12 years +</u> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							APPROX. MAX. INTERVAL BETWEEN ONSET AND DEATH 2 hrs.
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Feb 1, 1958, to March 30, 1968, that (I) (we) last saw the deceased alive on March 28, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Neri P. Campbell DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						22c. DATE SIGNED 3/30/68	
22d. PHYSICIAN'S NAME (Type) Neri P. Campbell						22e. ADDRESS 1629 Col. Rd.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 4, 1968		23c. NAME OF CEMETERY OR CREMATORY Brookside Cemetery		23d. LOCATION (City or Town) (County) (State) Watertown, New York	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, 5130 Wis. Ave N. W.				25a. REC'D BY REG. STRAR DATE APR 5 - 1968		25b. REGISTRAR'S SIGNATURE John Charles Judge	
Wash. D.C.							



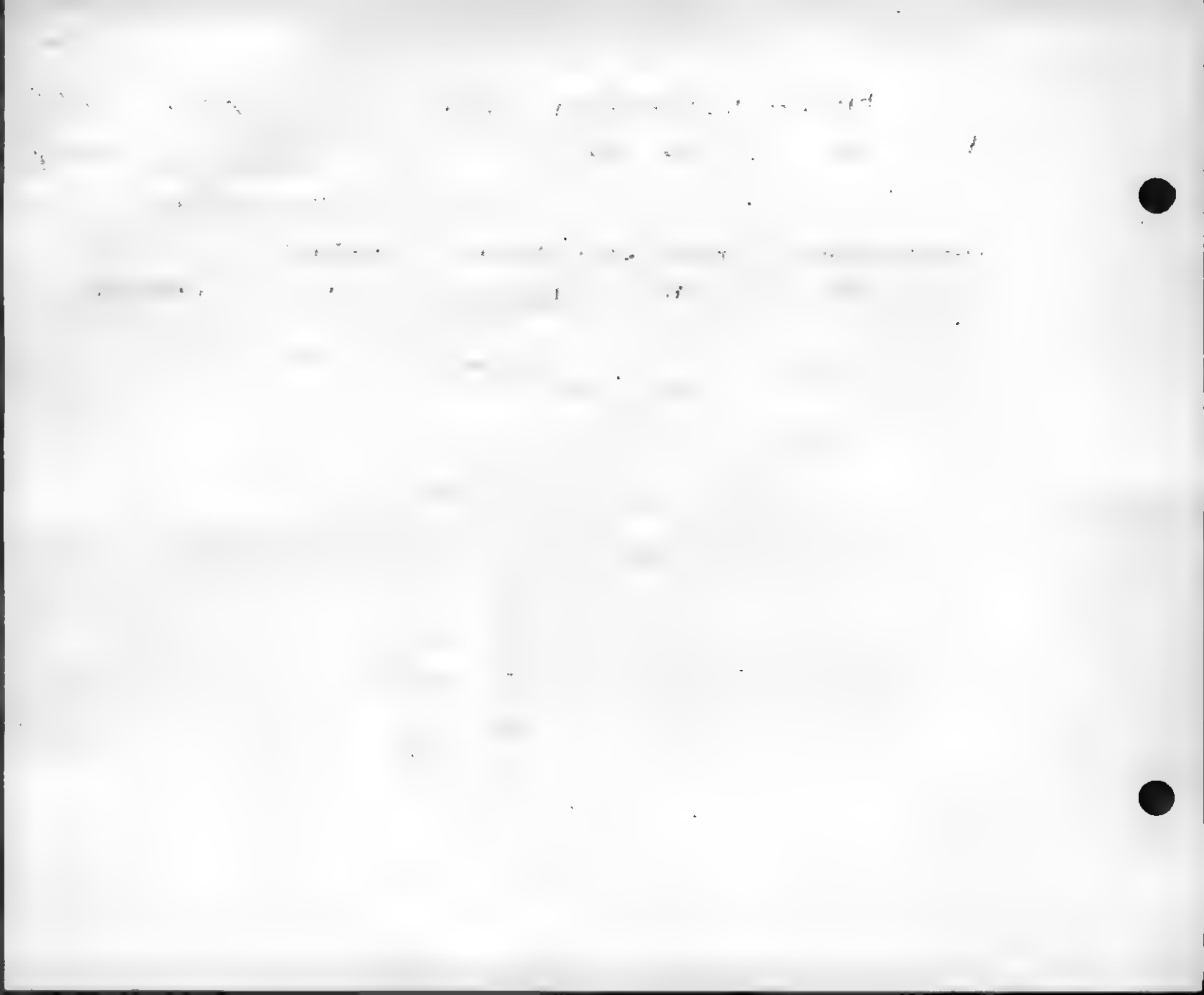
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) HILDA ELIZABETH PLITT			2a. DATE KNOWN OF ESTI- DEATH MATED X 3 15 1968 7:15 PM			2b. HOUR		
3 SEX F	4. RACE W	5. DATE OF BIRTH 4-23-96	6 AGE (in years last birthday) 71 YRS	7 UNDER YEAR MONTHS 71	8 UNDER 24 HRS HOURS 71	2c. DATE PRONOUNCED DEAD Month 3 Day 15 Year 1968 7:15 PM	2d. HOUR	
7a. BIRTHPLACE (State or foreign country) BALTIMORE		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.		
10. CITY OR TOWN OF DEATH TAKOMA PARK			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASH STATE HOSP			12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired.) ARTIST		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD			13b. COUNTY HOWARD			13c. CITY OR TOWN SIMPSONVILLE		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER Rt 32, Rt 1 Box 515					
14. FATHER'S NAME First Philip Middle PLITT Last PLITT			15. MOTHER'S MAIDEN NAME First FLORENCE Middle BRENNAN Last BRENNAN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO 220-05-5432			17. INFORMANT Philip REITER ADDRESS Box 515 Simpsonville Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage - 8/2.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Trauma from auto accident DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day Year 6 46 PM 3-15 1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) drove car into oncoming traffic		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Highway Route 29			21f. LOCATION Street or RFD No. City or Town County State Burtonville Shipping Center Burtonville Montgomery Md		
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE John G Ball M D			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 3/16/68		
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
ADDRESS (Street, city, town, or county)								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 3-20-68			23c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEMETERY		
23d. LOCATION (City or Town) (County) (State) WOODLAWN, BALTO MD			23e. RECORD BY REG STRAR DATE MAR 21 1968			23f. REGISTRAR'S SIGNATURE John G Ball		
24. FUNERAL DIRECTOR Shack Funeral Home			ADDRESS Ellicott City, Md					



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-103. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

430 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 8 Film G398 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) Lillian Mae Prather			2a DATE KNOWN OF ESTIMATED DEATH March 8, 1968			2b HOUR 2 A.M.		
3 SEX Fe.	4 RACE Cobol.	5 DATE OF BIRTH Jan. 6, 1890	6 AGE (in years last birthday) 78 YRS.	7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c DATE PRONOUNCED DEAD March 8, 1968	2d HOUR 7:30 A.M.	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md		
10 CITY OR TOWN OF DEATH Gaithersburg		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Route 2, Box 229		12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Gaithersburg		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER Route 2, Box 229
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Insufficiency 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Cardio Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH acute - years								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4129								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE John S. Ball		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED March 8, 1968		
ADDRESS (Street, city, town, or county)								
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 3-11-68		23c NAME OF CEMETERY OR CREMATORY Brooke Grove Cem.		23d LOCATION (City or Town) (County) (State) Laytonsville Montg. Md.		
24 FUNERAL DIRECTOR Robert L. Snowden Rockville, Md.				25a REC'D BY REGISTRAR Charles Judge		25b REGISTRAR'S SIGNATURE		
				DATE MAR 12 1968				

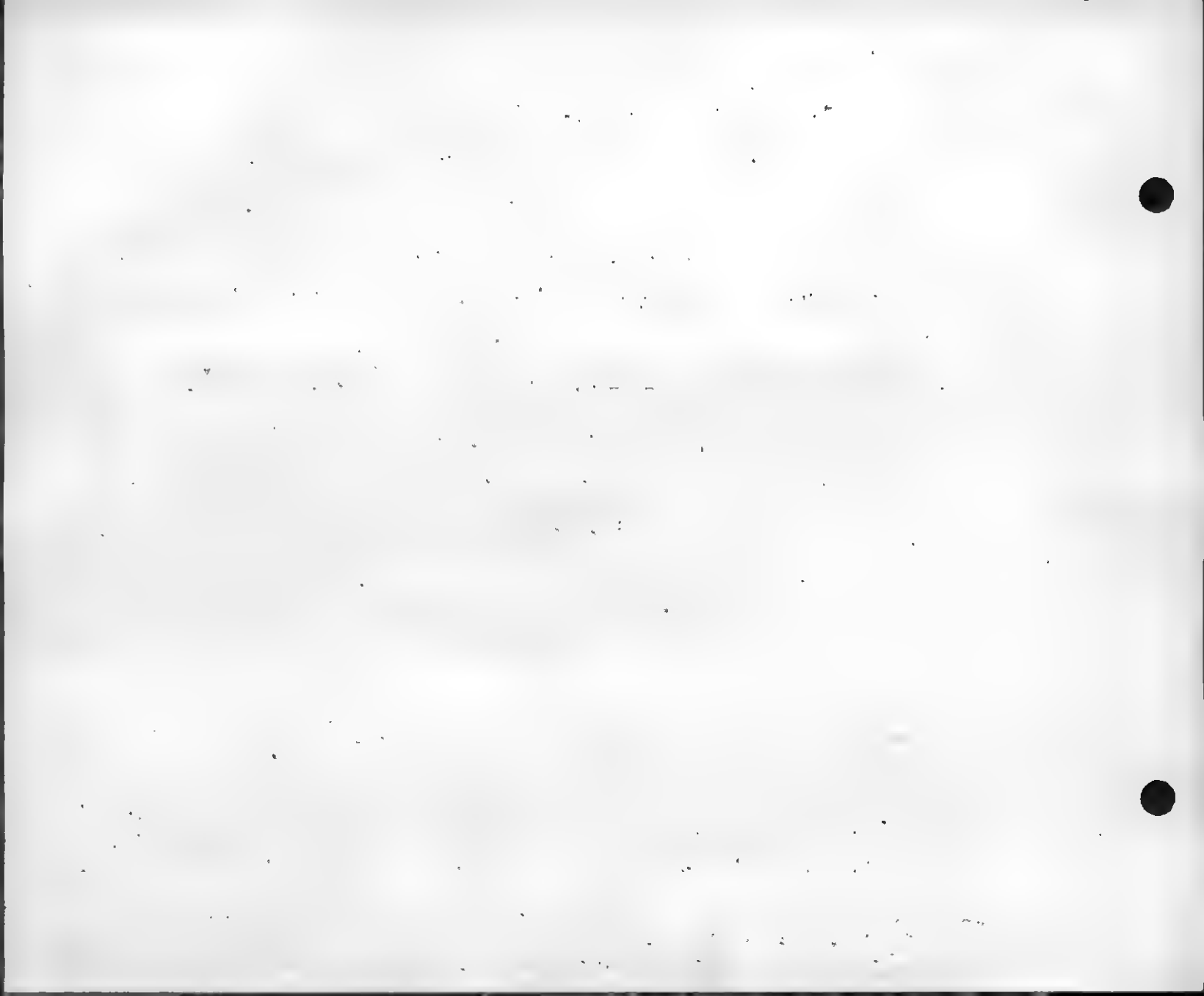


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>First Middle Last</i> <i>James J. Prather</i>			2a. DATE OF DEATH Month <i>3</i> Day <i>8</i> Year <i>68</i>			2b. HOUR <i>5:45 A.M.</i>	
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>10/15/82</i>		6. AGE (in years most birthday) <i>85</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>Tennessee</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery Co</i> Md	
10. CITY OR TOWN OF DEATH <i>Rockville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Falcons Valley Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. K NO OF BUSINESS OR INDUSTRY <i>Own Home</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Sp.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>8413 - 11th Avenue</i>		14. FATHER'S NAME First <i>Unknown</i> Middle <i></i> Last <i></i>		15. MOTHER'S MAIDEN NAME First <i>Sarah</i> Middle <i>Burns</i> Last <i></i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown? <i>No</i> (If yes give year or dates of service)		16b. SOCIAL SECURITY NO <i>577-16-7680</i>		17. INFORMANT <i>Mary Couch</i>		17. ADDRESS <i>8413 - 11th Avenue Silver Spring, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Infarction</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerosis</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4th</i> <i>4th</i> <i>1 yr.</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Carcinoma of Bladder & secondary uraemia</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <i>19</i> P.M. <i></i> Month <i></i> Day <i></i> Year <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. <i></i> City or Town <i></i> County <i></i> State <i></i>			
22a. I certify that (I) (this hospital) attended the deceased from <i>1/11, 1968</i> to <i>3/8, 1968</i> , that (I) (we) lost saw the deceased alive on <i>3/7, 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Stephen J. Jones</i>		22c. DATE SIGNED <i>3/8/68</i>		22d. PHYSICIAN'S NAME (Type) <i>Stephen Jones</i>		22e. ADDRESS <i>809 Viers Mill Road, Rockville, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Transit</i>		23b. DATE <i>March 8, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Hickman Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Hickman, Kentucky</i>	
24. FUNERAL DIRECTOR <i>Warner E. Humphrey, Inc.</i>		25a. REC'D BY REGISTRAR <i>Charles Jones</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>		25c. DATE <i>MAR 11 1968</i>	



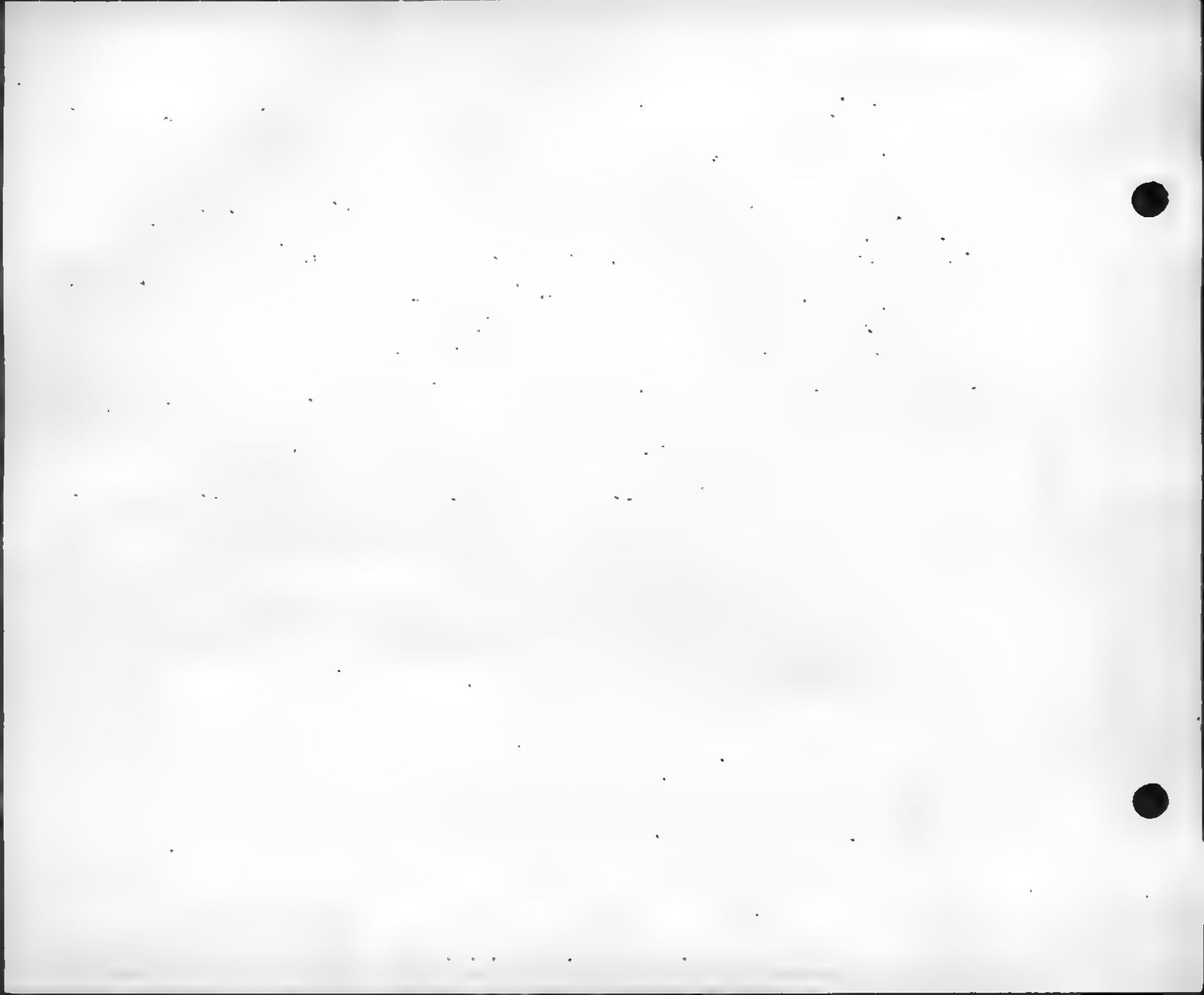
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Mertie S. Presler</i>			2a. DATE OF DEATH Month <i>March</i> Day <i>3</i> Year <i>68</i>			2b. HOUR <i>6:05</i> M	
3 SEX <i>female</i>		4 RACE <i>white</i>		5. DATE OF BIRTH <i>2/17/1887</i>		6. AGE (In years last birt day) <i>80</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>Ohio</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md	
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Suburban</i>		12a USJAL OCC. PATION (Kind of work done during most of working life, even if retired) <i>Teacher</i>		12b KIND OF BUSINESS OR INDUSTRY	
13a. USJAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>D. C.</i>		13b CITY OR TOWN <i>Washington</i>		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>2213-38th St. N.W.</i>	
14. FATHER'S NAME First <i>Winifred</i> Middle <i>S.</i> Last <i>Stahl</i>			15. MOTHER'S MAIDEN NAME First <i>Ida</i> Middle <i>May</i> Last <i>Hickman</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <i>Yes, no, or unknown</i>		16b SOCIAL SEC. NO. <i>579-626625</i>		17 INFORMANT <i>Marie Andrews/Tambler</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Pulmonary Edema</i>							<i>hour</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Bilateral Bronchial Pneumonia</i>							<i>1 Week</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Hypertension - Coronary Vascular Disease</i>							
19a. DATE OF OPERATION <i>3-3-68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (the hospital) attended the deceased from <i>2-29</i> , 19 <i>68</i> , to <i>3-3</i> , 19 <i>68</i> , that (i) (we) last saw the deceased alive on <i>3-3</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>P. P. Andrews MD</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <i>3-3-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>P. P. ANDREWS MD</i>				22e. ADDRESS <i>Washington D. C.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3-6-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Washington, D.C.</i>	
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc.</i> ADDRESS <i>5130 Wisc. Ave. N.W. Wash. D.C.</i>				25a. REC'D BY REGISTRAR <i>DIAR 8 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-toppers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) <i>Charles E. Ramsey</i>						2a DATE OF DEATH Month <i>3</i> Day <i>17</i> Year <i>68</i>			2b HOUR <i>11:45 P.M.</i>		
3 SEX <i>M</i>		4 RACE <i>W</i>		5. DATE OF BIRTH <i>5-29-1886</i>			6 AGE (In years last birthday) <i>81</i> YRS		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS M.N.
7a BIRTHPLACE (State or foreign country) <i>West Va.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md					
1d CITY OR TOWN OF DEATH <i>Rockville</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Potomac Valley Nursing Home</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Laborer</i>			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>md.</i>			13b COUNTY <i>Mont.</i>		13c CITY OR TOWN <i>Barnesville</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER		
14. FATHER'S NAME First Middle Last <i>Unknown</i>						15. MOTHER'S MAIDEN NAME First Middle Last <i>Unknown</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, give no, or unknown				16b SOCIAL SECURITY NO <i>233-16-9765A</i>		17 INFORMANT <i>Mrs. Edna Ramsey</i>			Address <i>Barnesville Md</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiovascular collapse</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>1</i> (b) <i>pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>generalized arteriosclerosis</i> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>cerebral thrombosis</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>unmed 18 hrs</i>	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>March 1, 1968</i> to <i>March 13, 1968</i> , that (I) (we) last saw the deceased alive on <i>March 12, 1968</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <i>Wilfred R. Ehrmantraut</i>						22c. DATE SIGNED <i>3/18/68</i>		22d. ADDRESS <i>Rockville Md</i>			
22d. PHYSICIAN'S NAME (Type) <i>Wilfred R. Ehrmantraut</i>						22e ADDRESS <i>11125 Rockville Pike</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b DATE <i>3/20/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Boysd Presbyterian</i>			23d. LOCATION (City or Town) (County) (State) <i>Boysd Montg. Md</i>			
24 FUNERAL DIRECTOR <i>Hilton Funeral Home Barnesville, Md</i>						25a. REC'D BY REGISTRAR <i>MAR 21 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or Print) <i>Sarah</i>			First <i>E</i>			Middle <i>Rawlins</i>			Last			
3 SEX <i>Fe.</i>		4 RACE <i>W.</i>		5 DATE OF BIRTH <i>Dec 13 1911</i>		6 AGE (in years last birthday) <i>56</i> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (State or foreign country) <i>New Jersey</i>			7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i>			
10 CITY OR TOWN OF DEATH <i>Bethesda</i>				11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>5800 Augusta Lane</i>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Me.</i>				13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Bethesda</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>5800 Augusta Lane.</i>		
14 FATHER'S NAME <i>Thomas</i>				First <i>T.</i>		Middle <i>Buchanan</i>		Last		15 MOTHER'S MAIDEN NAME <i>?</i>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <i>NO</i>				16b. SOCIAL SECURITY NO.		17. INFORMANT <i>Edwin F. Rawlins</i>				ADDRESS <i>above (11)</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Asphyxia from Drowning</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Cerebral Concussion.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Fall in bath Tub full of water.</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>11:17.</i> <i>5M:07.</i>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION <i>9/29/68</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Fell - striking head causing concussion and crown on tub of water.</i>								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>John G. Ball</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <i>March 2, 1968</i>				
EXAMINER'S NAME (Type) <i>John G. Ball</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
				ADDRESS (Street, city, town, or county)								
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>3/5/68</i>		23c NAME OF CEMETERY OR CREMATORY <i>Gettysburg Nat'l. Cem.</i>				23d LOCATION (City or Town) (County) (State) <i>Gettysburg, Penna.</i>				
24. FUNERAL HOME <i>St. Don. De Vol</i>				25. REC'D BY REGISTRAR <i>Charles Judge</i>				26. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
25. ADDRESS <i>2222 Wisc. Ave. Washington, D. C.</i>				DATE <i>MAR 7 1968</i>								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Items 21 film 398
15-13-Ce

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <i>Margaret W. Ridgway</i>		2a. DATE OF DEATH Month <i>March</i> Day <i>6</i> Year <i>1968</i>		2b. HOUR <i>10⁵⁵ P</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>14 DEC 1892</i>	6. AGE (In years last birthday) <i>75</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>New York</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i> Md	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL OR INSTITUTION (If in hospital give street address) <i>Suburban</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>retired</i>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUA. RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <i>DC</i>	13b. COUNTY <i>Washington</i>	13c. CITY OR TOWN <i>Washington</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>Ormy Street NW - 6300</i>
14. FATHER'S NAME First <i>ALEXANDER</i> Middle <i>WILSON</i> Last <i>HOWARD</i>	15. MOTHER'S MAIDEN NAME First <i>ANNIE</i> Middle <i>HOWARD</i> Last <i>HOWARD</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i> (If yes give war or dates of service)	16b. SOCIAL SECURITY NO. <i>561-42-5941</i>	17. INFORMANT <i>DAUGHTER - VIRGINIA CRAWFORD</i> Address <i>Charlottesville, Va</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aspiration gastric contents</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>5-1-0</i> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Associated gastric ulcer</i>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <i>1965</i> , 19 <i>6</i> MAR, 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>6 MAR</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>Walter Goozh MD</i>		DEGREE <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <i>WALTER GOOZH MD</i>		22e. ADDRESS <i>2309 SHOREFIELD RD WHEATON MD</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>3-9-1968</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Kensico Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Kensico, N.Y.</i>	
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc.</i> <i>5130 Wisc. Ave. N.W. Wash. D.C.</i>		25a. REC'D BY REGISTRAR DATE <i>MAR 13 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

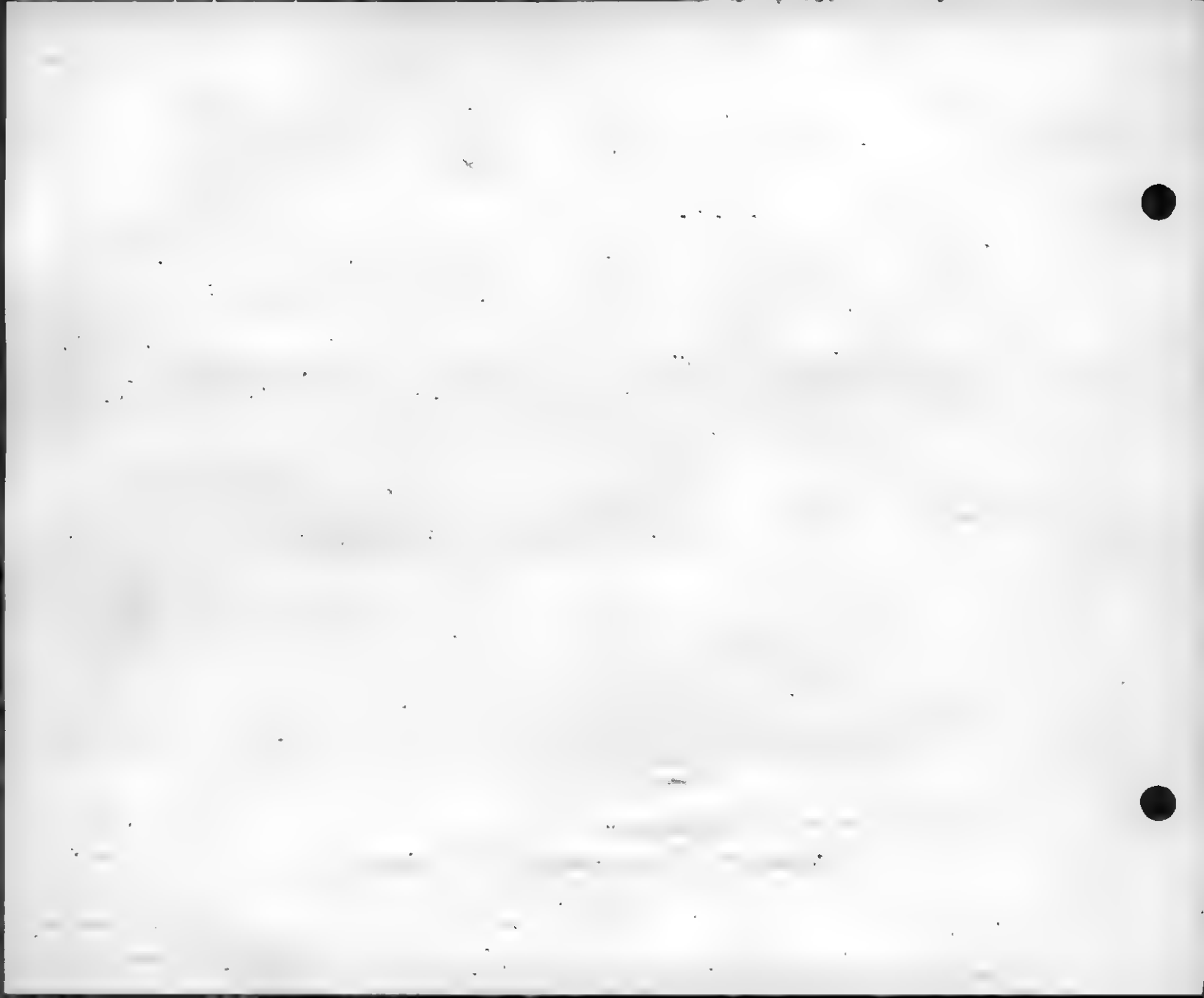


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MEDICAL CERTIFICATION

<div style="display: flex; justify-content: space-between;"> 04436 MARYLAND STATE DEPARTMENT OF HEALTH </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div>											
1. DECEASED NAME (Type or print)				First Middle Last				2a. DATE OF DEATH			2b. HOUR
Armando				Ridolfi				3 Month 25 Day 68 Year			1:11 PM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		7. UNDER 1 YEAR		7. UNDER 24 HRS.
M. F.		W. N.		12/15/18			49 YRS		MONTHS DAYS		HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Italy		U. S. A.				Montgomery Md					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring			Holy Cross Hospital			Barber			W. H. H. H.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland				Prince Georges		Hyatts, Md		YES		6406 - 86th Ave	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
Giocando Ridolfi				Elizabeth Cortalina							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO		17. INFORMANT					
No				320-14-0220		Celeste L. Ridolfi 6406 - 86th Ave Hyatts, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ruptured Cerebral Aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Subarachnoid hemorrhage due to</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ruptured Berry Aneurysm</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
				3-8		1968		3-25		1968	
22a. I certify that (I) (this hospital) attended the deceased from <u>3-8</u> , 19 <u>68</u> , to <u>3-25</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>3-25</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Bernard A. Fitzgerald</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22c. DATE SIGNED <u>3-25-68</u>			
22d. PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>								22e. ADDRESS <u>217 UNIV BLVD E, S.L. SP., MD.</u>			
23a. BURIAL, CREMATON, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		March 27, 1968		Lincoln Cemetery		Prince Georges Co		Maryland			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
S. Glen Carter		MAR 28 1968		Johnas J. J.							



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)		First WILLIAM	Middle	Last RIEMER	2a DATE KNOWN OF ESTIMATED DEATH Month March Day 31 Year 1968		2b HOUR 6:45 A.M.
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH 8/5/1895		6 AGE (In years last birthday) 72 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	2c DATE PRONOUNCED DEAD Month Mar. Day 31 Year 1968	
7a BIRTHPLACE (State or foreign country) New York, N.Y.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery	
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban			12a USUAL OCCUPATION (Kind of work done during last 12 months) Retired Mechanical Ins.		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE New York		13b COUNTY Ulster		13c CITY OR TOWN Accord		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME Meyer		First Riemer		Last Fannie		Middle Berman	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown)		16b SOCIAL SECURITY NO.		17 INFORMANT Wife Eva Riemer		ADDRESS Same as Item 13.	
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary Artery Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden Reap		EXAMINER'S NAME (Type) Belden Reap		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED 3/31/1968	
23a BURIAL, CREMATION REMOVAL (Specify) Removal		23b DATE 4-3-68		23c NAME OF CEMETERY OR CREMATORY Beth David Cemetery		23d LOCATION (City or Town) (County) (State) Elmont, New York.	
24 FUNERAL DIRECTOR R.A. Humphrey		ADDRESS Bethesda, Md.		25a REC'D BY REGISTRAR APR 3 - 1968		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 - should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA 15 (4)
30M REV 1/68

438
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

4426

1. DECEASED NAME (Type or print) James		First M.		Middle Rinehart		Last		2c. DATE OF DEATH March Month 17 Day 1968 Year		2b. HOUR 9³⁰ AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Nov. 1880		6. AGE (In years last birthday) 87		IF UNDER 1 YEAR MONTHS 1 DAYS 1		IF UNDER 24 HRS HOURS 1 MIN.	
7a. BIRTHPLACE (State or foreign country) New Market, Md.		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		Md			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Colonial Villa Nurs. Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Painter		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Mont.		13c. CITY OR TOWN Lewisdale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7002 - 20th Avenue			
14. FATHER'S NAME John		First R		Middle Rinehart		Last		15. MOTHER'S MAIDEN NAME Katherine		First Eador	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO 578-01-9313		17. INFORMANT Nursing Home Records-12325 New Hampshire Ave/		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 4 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 352X (b) Arterio sclerosis, generalized DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mo	
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Feb 19, 1968 , to Mar 17, 1968 , that (I) (we) last saw the deceased alive on Mar 16, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE William F. Simpson, MD DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 3/17/1968	
22d. PHYSICIAN'S NAME (Type) William F. Simpson MD										22e. ADDRESS 6216 N.H. Ave AF	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE March 20, 1968		23c. NAME OF CEMETERY OR CREMATORY Geo. Washington Memorial Quattville, Maryland		23d. LOCATION (City or Town) (County) (State)					
23e. FUNERAL DIRECTOR C. Glen Carter		23f. ADDRESS 2474 Georgia Ave.		23g. FIRM Garner E. Purphrey, Inc.		23h. CITY Silver Spring, Md.		25a. REC'D BY REGISTRAR DATE MAR 21 1968		25b. REGISTRAR'S SIGNATURE Charles J. Judge	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with four PM's. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month Day Year		2b. HOUR
RONALD		DUANE	RITCHEY	3 11 1968		9:40 AM	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
Male	White	11/29/33	34 YRS			March 11 1968	9:40 AM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH	
Penna.		USA				Montgomery Md.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross Hospital		Classified--Defense Dept.		Govt.	
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET AND NUMBER	
Maryland		Pr. Georges		Laurel		15901 Kerr Rd.	
14 FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First Middle Last
Ralph		Ritche6	Willownet	Walters			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Air Force		1955-57		Wife,		Elenore Ritchey 15901 Kerr Rd. Laurel, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Insufficiency, Acute</u> 4129 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u>Arteriosclerotic Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> Years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)		JOHN G. BALL M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		March 12, 1968	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		3-16-68		Forest Lawn		Johnstown Pa.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
He Witt Lennedman Laurel Md				MAR 15 1968			

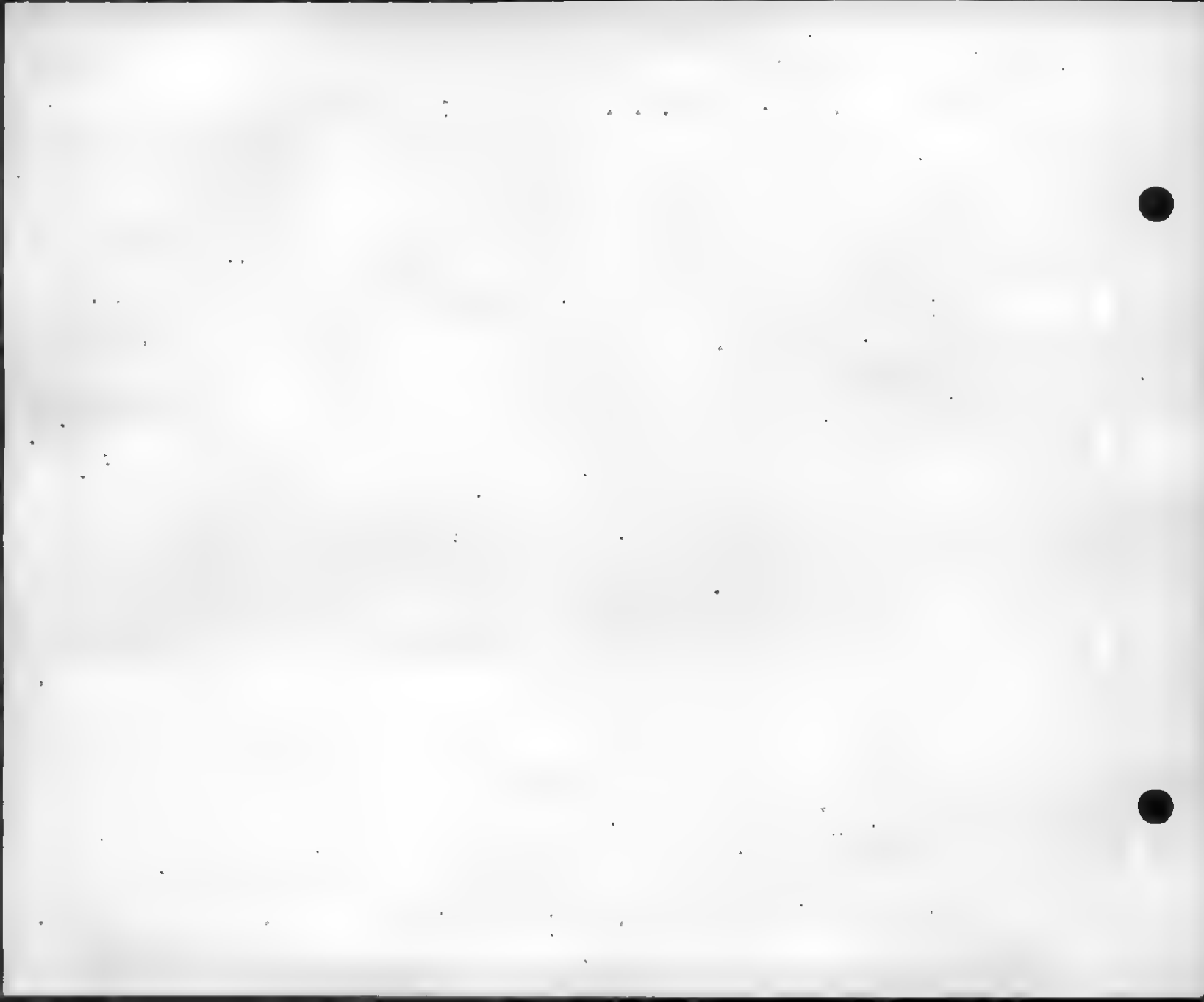


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH										
1. DECEASED NAME (Type in full) First Middle Last STISIER M. Generosa C.S.C. (Roache)			2a. DATE OF DEATH Month 3 Day 20 Year 68 2:30 PM			2b. HOUR				
3. SEX Female		4. RACE White		5. DATE OF BIRTH 3/29/1894		6. AGE (in years last birthday) 75 YRS		7. UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (State or foreign country) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md				
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Clergy - Sister		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admittance) STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4920 Strathmore Ave.	
14. FATHER'S NAME First Middle Last JAMES J. ROCHE				15. MOTHER'S MAIDEN NAME First Middle Last MARY HAGGERTY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL		Address RECORDS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>410.9</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arterio M.I.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cor. Arteriosclerosis</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>1 hr</u> <u>10 yr</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Postarthritic severe</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from <u>2/1/1958</u> , to <u>3/20/1968</u> , that (I) (we) last saw the deceased alive on <u>3/20/1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Stephen R. Jones MD</u> DEGREE <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <u>3/20/68</u>				
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS <u>Rockville, Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Type)		23b. DATE <u>3/23/1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>WASH. D.C.</u>				
24. FUNERAL DIRECTOR <u>Hanlon Funeral Home</u>				ADDRESS <u>4748 Wm Wash. DC</u>		25a. REC'D BY REGISTRAR <u>MAH 27 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

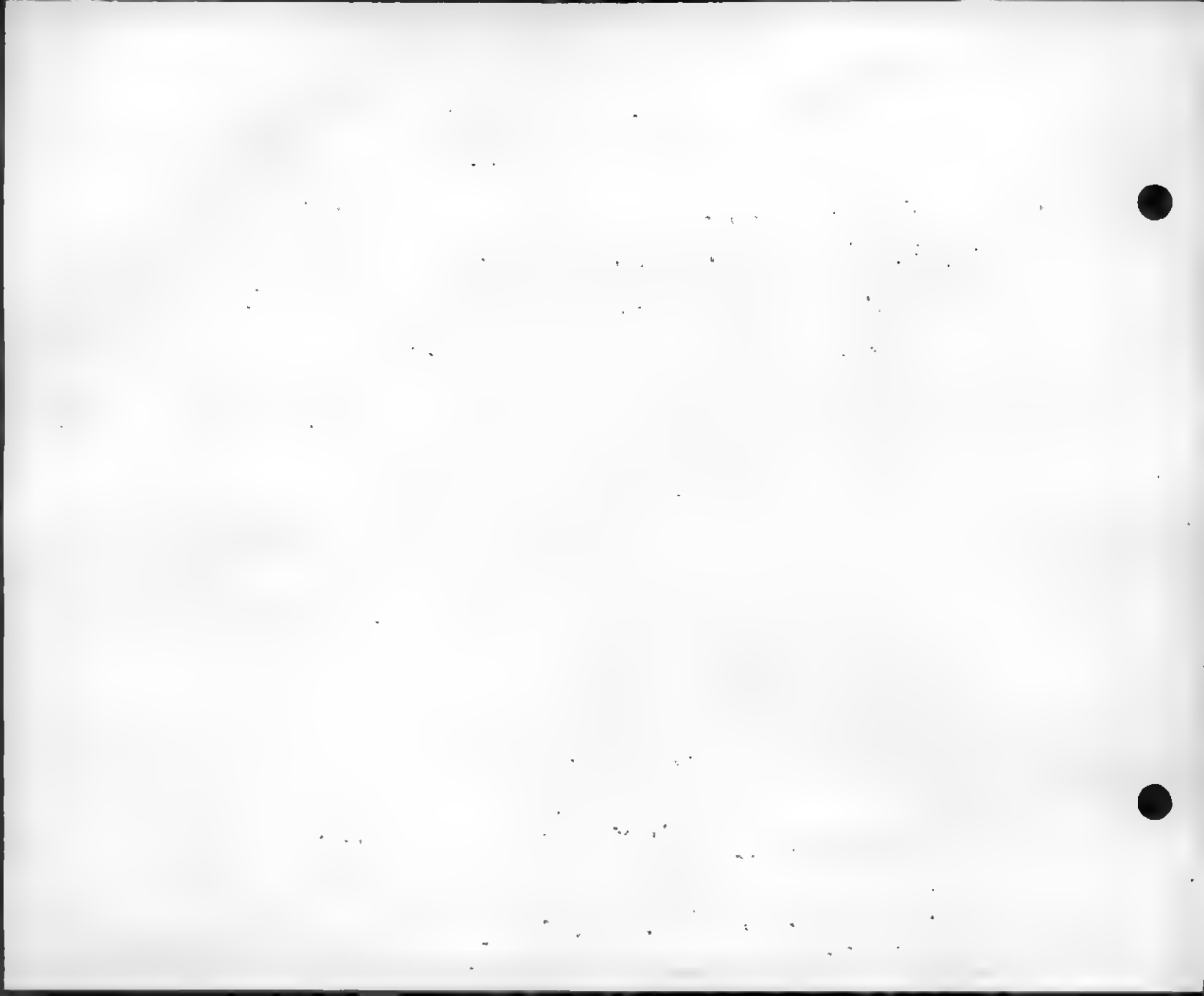
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

4429

1. DECEASED NAME (Type or print) First Middle Last <i>Lillian C. Robertson</i>			2a. DATE OF DEATH Month <i>March</i> Day <i>25</i> Year <i>1968</i>		2b. HOUR <i>10:00 AM</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>Nov. 23, 1908</i>		6. AGE (In years last birthday) <i>69</i> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i> Md.		
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Fairland Nursing Home</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>housewife</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Virginia</i>	13b. COUNTY <i>Arlington</i>	13c. CITY OR TOWN <i>Arlington</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>3115 South High Street</i>	
14. FATHER'S NAME First Middle Last <i>Cornelius Hall</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Lillian Arnold</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service) <i>No</i>		16b. SOCIAL SECURITY NO. <i>yes</i>		17. INFORMANT <i>4508 Landmark Street Constance Jew Rockville, Maryland</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Carcinoma of Bowel</i> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 YR. 2-3 YRS.</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>1537</i>					
19a. DATE OF OPERATION <i>Jan 1968</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Obstruction of Bowel</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>3/7</i> , 19 <i>68</i> , to <i>3/25</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>3/25</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Raymond T. Benack</i>		22c. PHYSICIAN'S NAME (Type) <i>Raymond T. Benack</i>		22d. ADDRESS <i>4115 Collic Drive Silver Spring, Maryland</i>	
22e. DATE SIGNED <i>3/25/68</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Mar. 27, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>	
23d. LOCATION (City or Town) (County) (State) <i>Suitland Maryland</i>					
24. FUNERAL DIRECTOR <i>James E. Humphrey, Inc.</i>		24a. ADDRESS <i>443 Georgia Ave. Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR <i>DATE MAR 29 1968</i>	
25b. REGISTRAR'S SIGNATURE <i>James E. Humphrey, Inc.</i>					



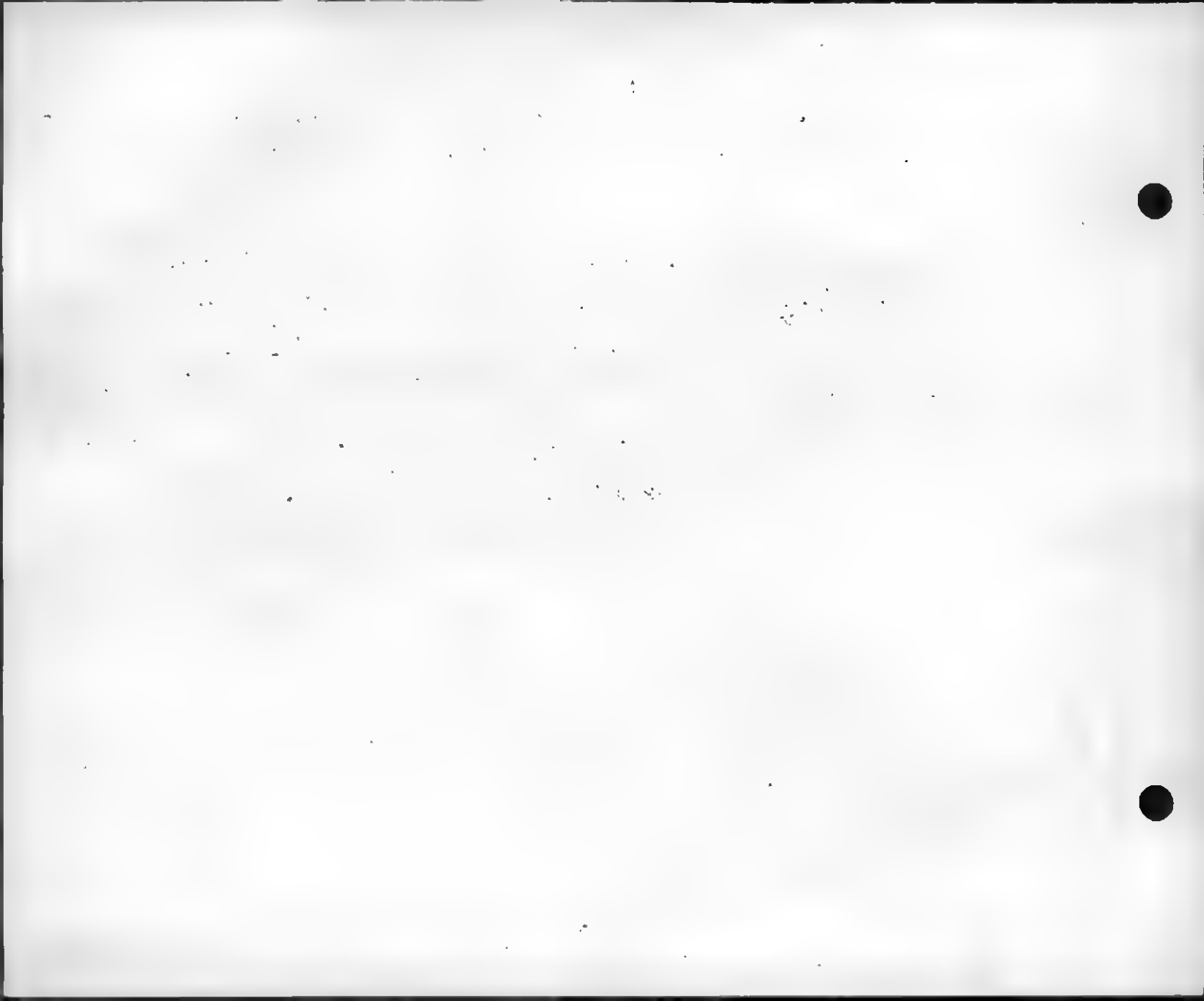
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) <u>Thomas</u> First <u>L</u> Middle <u>Robertson</u> Last <u>Jr.</u>			2a. DATE OF DEATH Month <u>May</u> Day <u>11</u> Year <u>1968</u>			2b. HOUR <u>9</u> MIN <u>15</u> AM <input checked="" type="checkbox"/> PM <input type="checkbox"/>	
3 SEX <u>Male</u>		4. RACE <u>white</u>		5 DATE OF BIRTH <u>Oct 4 1897</u>		6 AGE (In years last birthday) <u>70</u> YRS.	
7a BIRTHPLACE (State or foreign country) <u>D.C.</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <u>MONTGOMERY</u> Md	
10. CITY OR TOWN OF DEATH <u>Kensington</u>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>Kensington Gardens Sanit</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Seaman Merchant Marine</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>M.D.</u> COUNTY <u>Prince Georges</u>		13b. CITY OR TOWN <u>Capital Hgts</u>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>831-58th Ave.</u>	
14 FATHER'S NAME First <u>John</u> Middle <u>Robertson</u> Last <u>Robertson</u>			15. MOTHER'S MAIDEN NAME First <u>Margaret</u> Middle <u>Glynn</u> Last <u>Glynn</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>Yes</u> (If yes give war or dates of service) <u>WWI</u>		16b. SOCIAL SECURITY NO		17. INFORMANT <u>John D. Robertson - Son</u> Address <u>3819 Thomas Rd Landover, Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>3 yrs</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>45</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <u>19</u> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>4-27, 1966</u> to <u>3-11, 1968</u> , that (I) (we) last saw the deceased alive on <u>3-7-68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>D-P Sengstack MD</u> DELEGATE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <u>3-11-68</u>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>3-14-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>Ft Myer - Va</u>	
24. FUNERAL DIRECTOR <u>Lee Funeral Home</u> ADDRESS <u>300 4th St N.E. Wash. D.C.</u>				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
				DATE <u>MAR 13 1968</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

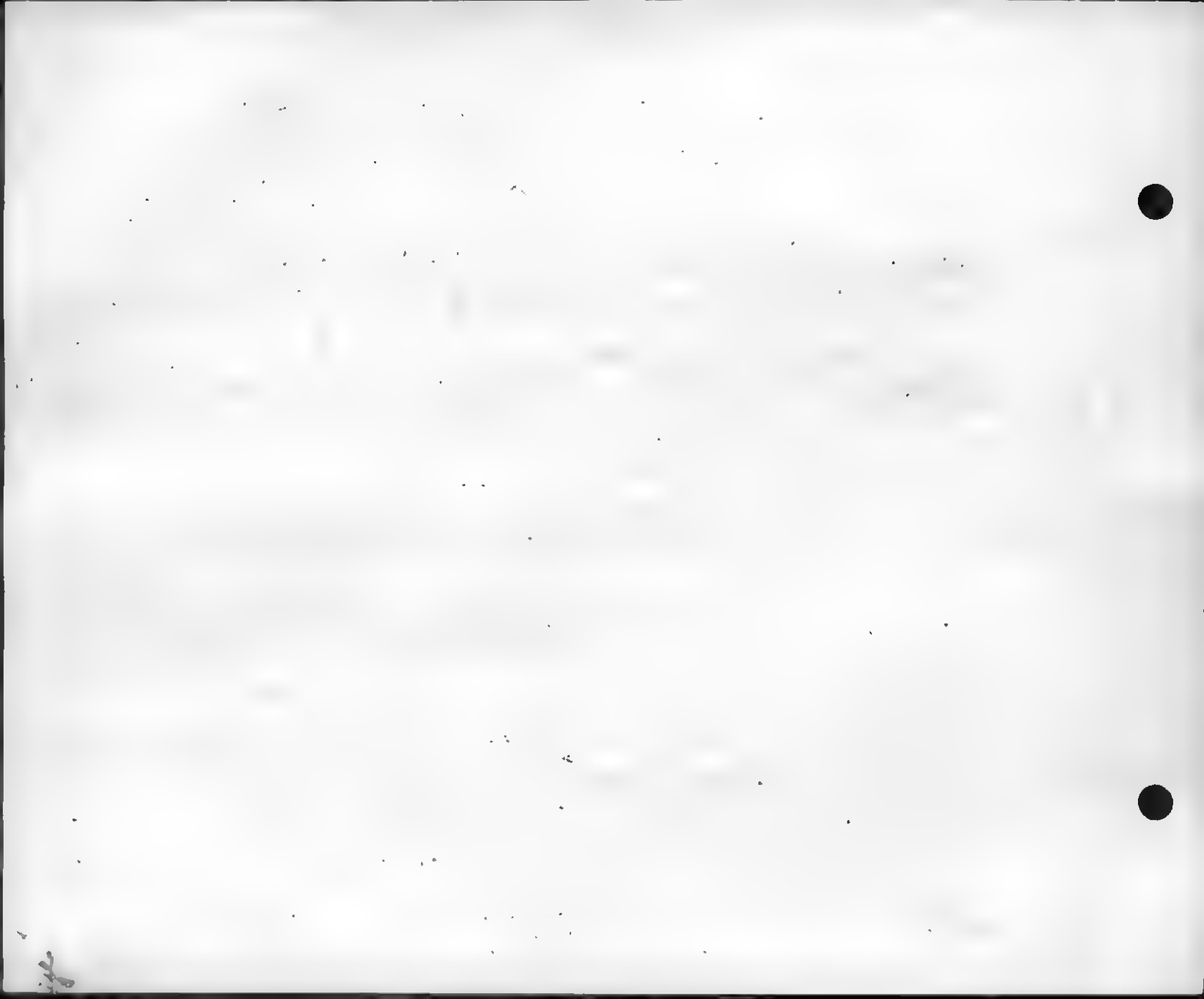
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04431

1. DECEASED-NAME (Type or print) <i>Theresa Goldie Rothchild</i>			2a. DATE OF DEATH Month <i>March</i> Day <i>15</i> Year <i>1968</i>			2b. HOUR <i>9:52 PM</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>10-19-21</i>		6. AGE (In years lost birthday) <i>46</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>Mass.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington Sanitarium & Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Takoma Park</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>7777 Maple Avenue</i>		14. FATHER'S NAME First <i>David</i> Middle <i>Eisen</i> Last <i>Eisen</i>		15. MOTHER'S MAIDEN NAME First <i>Frieda</i> Middle <i>Hester</i> Last <i>Hester</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT <i>Records - Washington Sanitarium & Hospital</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>RESPIRATORY FAILURE</i> <i>NO</i> DUE TO, OR AS A CONSEQUENCE OF, (b) <i>CARCINOMATOSIS</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>CARCINOMA OF COLON</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 DAYS</i> <i>1 MO.</i> <i>1 YR.</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION <i>JAN 1967</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>CA OF COLON RESECTED</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>2-29</i> , 19 <i>66</i> , to <i>3-15</i> , 19 <i>68</i> , that (I) (my) last saw the deceased alive on <i>3-15</i> , 19 <i>68</i> and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above, (I) (my) (did not) view the body after death.							
22b. SIGNATURE <i>Dwight R. Smith</i> M.D. DEGREE				22c. DATE SIGNED <i>3-16-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>DWIGHT R. SMITH</i>				22e. ADDRESS <i>800 PERSHING DR. SIL. SPR. MD.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3-17-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>New Montefiore Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Pinelawn, New York</i>	
24. FUNERAL DIRECTOR <i>Donald M. Stein</i> <i>Hebrew Memorial Funeral Home</i>				25a. REC'D BY REGISTRAR DATE <i>MAR 18 1968</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

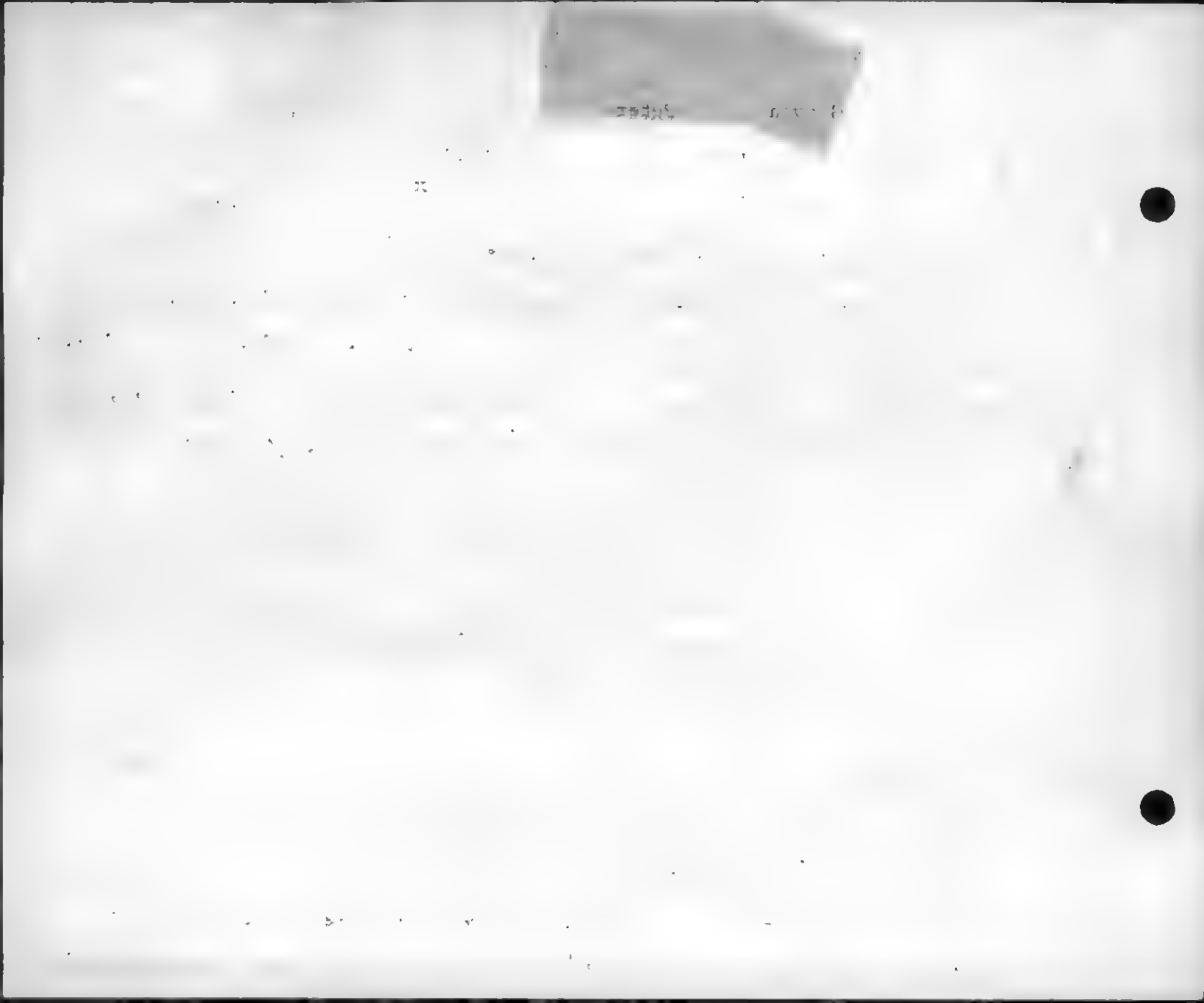


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Steven Middle Peter Last Roush			2a. DATE OF DEATH Month March Day 23 Year 1968			2b. HOUR 1:20 P.M.					
3. SEX Male		4. RACE White		5. DATE OF BIRTH March 22, 1968		6. AGE (In years last birthday) YRS MONTHS DAYS		IF UNDER 1 YEAR HOURS MIN		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Takoma Park			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San & Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY P.G.		13c. CITY OR TOWN Takoma Park		13d. INSIDE CITY EMB-157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7613 16th Ave.		
14. FATHER'S NAME First Marvin Middle Leroy Last Roush			15. MOTHER'S MAIDEN NAME First Joanne Middle Rae Last Witham								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown no			16b. SOCIAL SECURITY NO.		17. INFORMANT Address Father 7613 16th Ave., Takoma Park, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Respiratory Distress Syndrome</u> 776.2 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Prematurity</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Marvin Mones, M.D.</u> DEGREE											22c. DATE SIGNED <u>3/23/68</u>
22d. PHYSICIAN'S NAME (Type) Marvin Mones, M.D.,			22e. ADDRESS 9801 Georgia Ave., Silver Spring, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 3-23-68		23c. NAME OF CEMETERY OR CREMATORY Washington San & Hospital			23d. LOCATION (City or Town) Takoma Park, Mont. Md.		23e. LOCATION (County) (State)		
24. FUNERAL DIRECTOR J. R. Ruffcorn 7600 Carroll Ave., Takoma Park				ADDRESS		25a. REC'D BY REGISTRAR DATE <u>APR 1 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



FOR STATE HEALTH DEPT.

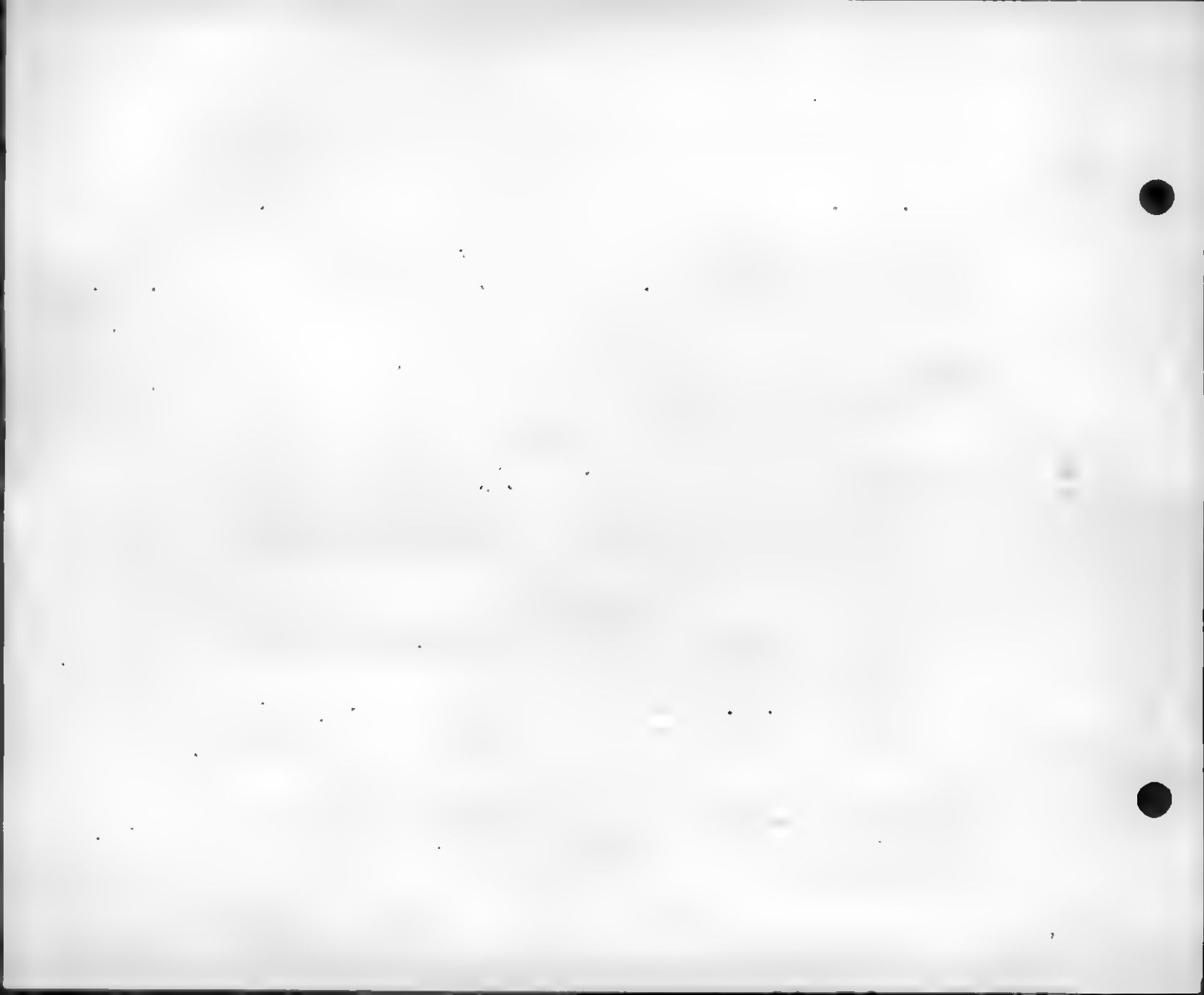
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the death certificate. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print) FREDERICK RHINEHART RUPPERT			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTI MATED <input type="checkbox"/> 3 27 1968			2b HOUR 3:50 PM			
3 SEX Male	4 RACE White	5 DATE OF BIRTH 7/10/08	6 AGE (in years last birthday) 59 YRS	F UNDER 1 YEAR MONTHS 0 DAYS 0		F UNDER 24 HRS HOURS 0 MIN 0		2c DATE PRONOUNCED DEAD Month 3 Day 27 Year 1968	2d HOUR 3:50 PM
7a BIRTHPLACE (State or foreign country) Wash., D.C.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery			
10 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.			12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired.) Electrician		12b KIND OF BUSINESS OR INDUSTRY		
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b COUNTY Montg.		13c CITY OR TOWN Sil. Spr.		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER 10204 Bieber Bl. S.S.	
14. FATHER'S NAME First Charles Middle Ruppert Last Ruppert			15 MOTHER'S MAIDEN NAME First Martha Middle Barchett Last Barchett			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			
16b SOCIAL SECURITY NO 578-06-5177			17 INFORMANT Wife, Pansy Ruppert			ADDRESS 10204 Bieber Pl. Sil. Spr., Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Extreme Internal Injuries including crushed chest with Internal Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Injuries including crushed chest with Internal Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) chest with Internal Hemorrhage									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION 3-27-68			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day Year 3-27-68		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 item 18) Auto started later started accidentally ran over deceased's chest					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street		21f LOCATION Street or RFD No Woodmore Esso Station City or town Silver Spring County Montg. State Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Belden R. Reap			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 3/27/1968			
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (City or town or county)			
23a BURIAL CREMATION, REMOVAL (Specify) 3-29-68		23b DATE 3-29-68		23c NAME OF CEMETERY OR CREMATORY Parkman Cem.		23d LOCATION (City or town) (County) (State) Rockville Md			
24 FUNERAL DIRECTOR W. W. Chambers			ADDRESS 14th & Chapin St.			25a REC'D BY REG. STRAR APR 3 - 1968		25b REGISTRAR'S SIGNATURE Charles J. ...	



MARYLAND STATE DEPARTMENT OF HEALTH

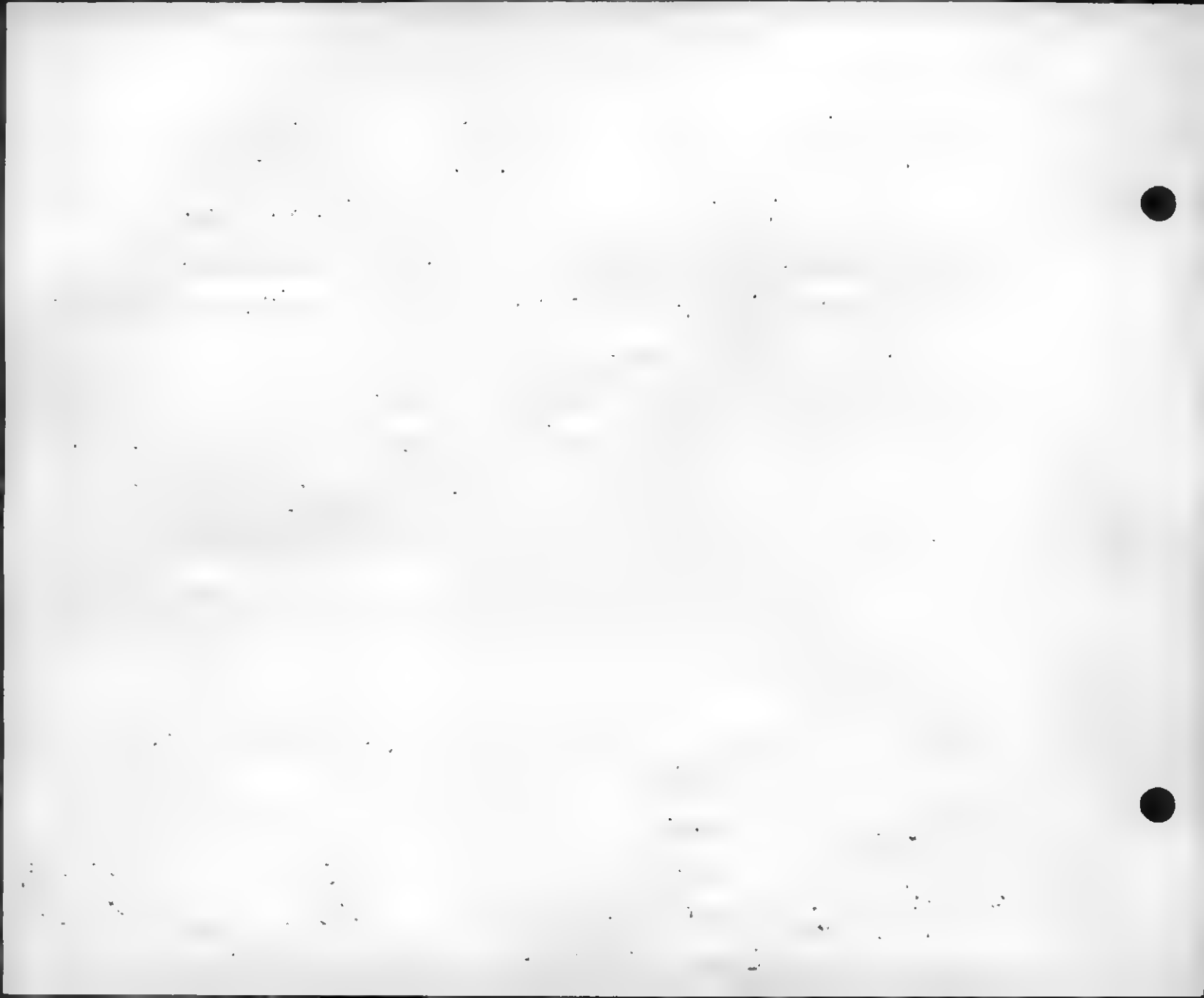
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 4 & 5 Film G398 3/13/68 **CERTIFICATE OF DEATH**

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1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b HOUR M			
Arvo			Waisend	SAAARI		March 6 1968						
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years lost birthday)		F UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN				
male	White	4-18-1918 1919		48 YRS.								
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
		United States				Montgomery Md.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Takoma Park			Washington Sanatorium Hosp			U.S. Information Agency						
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
Maryland		Montgomery		Silver Spring				10409 Brookmead Dr. S.S.				
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
Arvo			E.	Saari		Elsa Karinen						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT						
No				5 77-12-7681		Patient Record. (wife)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aspiration pneumonia, left lobe, with lung metastases</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastases</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>7 weeks</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION			Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1, 1968</u> , to <u>Mar 6, 1968</u> , that (I) (we) last saw the deceased alive on <u>March 6, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Samuel T. Kimble</u> M.D. DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>3-6-68</u>				
22d. PHYSICIAN'S NAME (Type) <u>S. T. KIMBLE</u>						22e. ADDRESS <u>9801 Greenview Ave. Silver Spring, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)		
		<u>March 9, 1968</u>		<u>St. Luke's</u>		<u>Bethesda</u>		<u>Dist. of Col.</u>		<u>Md.</u>		
24. FUNERAL DIRECTOR <u>Arthur Walters</u> ADDRESS <u>254 Carroll St. NW</u>						25a. REC'D BY REGISTRAR DATE <u>MAR 11 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <u>Sora</u> First <u>Sorker</u> Middle <u>Sorker</u> Last			2a DATE OF DEATH Month <u>March</u> Day <u>27</u> Year <u>1968</u>			2b HOUR <u>7:48</u> M					
3 SEX <u>Female</u>		4 RACE <u>WHITE</u>		5. DATE OF BIRTH <u>9/1/199</u>		6 AGE (In years last birthday) <u>68</u> YRS.		IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u>		IF UNDER 24 HRS HOURS <u>0</u> MIN <u>0</u>	
7a. BIRTHPLACE (State or foreign country) <u>Bethesda</u>		7b. CITIZEN OF WHAT COUNTRY? <u>LATVIA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md					
10. CITY OR TOWN OF DEATH <u>Bethesda</u>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban</u>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Retired Housewife</u>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>md</u>			13b COUNTY <u>Mont</u>			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13d STREET AND NUMBER <u>8009 Eastern Ave</u>		
14 FATHER'S NAME First <u>Mandel</u> Middle <u>Finn</u> Last			15 MOTHER'S MAIDEN NAME First <u>Don - Morris</u> Middle <u>Sorker</u> Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>No</u> (If yes give war or dates of service)			16b SOCIAL SECURITY NO <u>579-36-5550</u>			17 INFORMANT <u>9120 f row Address Bethesda Md.</u> <u>Don - Morris Sorker</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma, lung, diffuse, bilateral</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3-4 weeks</u>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>NONE</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC)			21f LOCATION Street or RFD No City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from <u>MARCH, 1966</u> , to <u>3/27, 1968</u> , that (I) (we) last saw the deceased alive on <u>3/27/68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Lawrence D. Marcus MD</u>						22c. DATE SIGNED <u>3/27/68</u>					
22d. PHYSICIAN'S NAME (Type) <u>LAWRENCE D. MARCUS MD</u>						22e. ADDRESS <u>1111 Spring St. Silver Spring, Md</u>					
23a. BURIAL OR CREMATION, (Specify)			23b. DATE <u>3/28/68</u>			23c. NAME OF CEMETERY OR CREMATORY <u>D.C. LODGE Cem.</u>			23d. LOCATION (City or Town) (County) (State) <u>WASHINGTON, DC</u>		
24. FUNERAL DIRECTOR <u>GOLDBERG FUNERAL HOME</u>						25a. REC'D BY REGISTRAR <u>42179-20</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
						DATE <u>MAR 29 1968</u>					

MEDICAL CERTIFICATION



CERTIFICATE OF DEATH

44431

1 DECEASED NAME (Type or print) Joseph J. ...			First Middle Last Joseph J. ...			2a. DATE OF DEATH Month Day Year March 1968			2b. HOUR 1:50 PM		
3 SEX Male			4. RACE White			5. DATE OF BIRTH 14 July 1908			6. AGE (In years lost birthday) 59 YRS		
7a. BIRTHPLACE (State or foreign country) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md		
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Francis Xavier			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clerical			12b. KIND OF BUSINESS OR INDUSTRY ---		
13a. USUAL RESIDENCE (Where deceased lived if institut an. Residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Washington			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 127 ...			14. FATHER'S NAME First Middle Last Simon F. ...			15. MOTHER'S MAIDEN NAME First Middle Last Julia C. ...					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO 578-40-5750			17. INFORMANT The Medical Records, Address The Clinical Center, Baltimore, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left uncus herniation, brain DUE TO, OR AS A CONSEQUENCE OF (b) Partial occlusion, right coronary artery DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary congestion & emphysema									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-3 days 1 week years ?		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Psoriasis - chronic duodenal ulcer											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from ... to ... 1968, that (I) (we) last saw the deceased alive on ... 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Richard H. Creech M.D. DEGREE ATTENDING <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF <input checked="" type="checkbox"/> PHYS. PHYS.									22c. DATE SIGNED 9 March 1968		
22d. PHYSICIAN'S NAME (Type) Richard H. Creech, M. D.									22e. ADDRESS The Clinical Center, Baltimore, Maryland		
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial			23b. DATE 3/12/68			23c. NAME OF CEMETERY OR CREMATORY St. Francis Xavier			23d. LOCATION (City or Town) (County) (State) Cresson Pennsylvania		
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home						ADDRESS 1331 Rockville Pike Rockville, Md.			25a. REC'D BY REGISTRAR DATE MAR 12 1968		
						25b. REGISTRAR'S SIGNATURE Charles ...					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b _____ d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>10709 Glenwild Road</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>10709 Glenwild Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Corretta Byam Sarra</u> First Middle Last 4. DATE OF DEATH <u>Mar 12 1968</u> Month Day Year				5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>10-19-1910</u> 9. AGE (In years last birthday) <u>57</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u> 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (County & State, or foreign country) <u>New York</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>William C. Byam</u> 14. MOTHER'S MAIDEN NAME <u>Clara Bingham</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ 16. SOCIAL SECURITY NO. _____ 17. INFORMANT <u>Alvin A. Sarra - See Item No. 2.</u> Address				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>3480 Amyotropic Lateral Sclerosis</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>3561</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) _____ 20c. TIME OF INJURY Month, Day, Year <u>July 9 1968</u> Hour a.m. _____ p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) (County) (State) _____				21. I certify that (I) (this hospital) attended the deceased from <u>July 9 1968</u> to <u>Mar 12 1968</u> that (I) (we) last saw the deceased alive on <u>Jan 24 1968</u> and that death occurred at <u>7 M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>George L Ball</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. PHYSICIAN'S NAME (Type) <u>George L Ball</u> 22b. DATE SIGNED <u>Mar 12 1968</u> 22c. ADDRESS <u>10620 Georgia Ave</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> 23b. DATE THEREOF <u>3-16-1968</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Cook Cemetery</u> 23d. LOCATION (city, town or county) (State) <u>Oneonta, N.Y.</u>			
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> ADDRESS <u>5130 Wisc. Ave. NW.</u> <u>Wash. D.C.</u> 25a. REC'D BY REGISTRAR <u>DATE MAR 14 1968</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

Medical Examiner or Hospital Coroner or State Registrar
 case and for an authorized me to sign
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



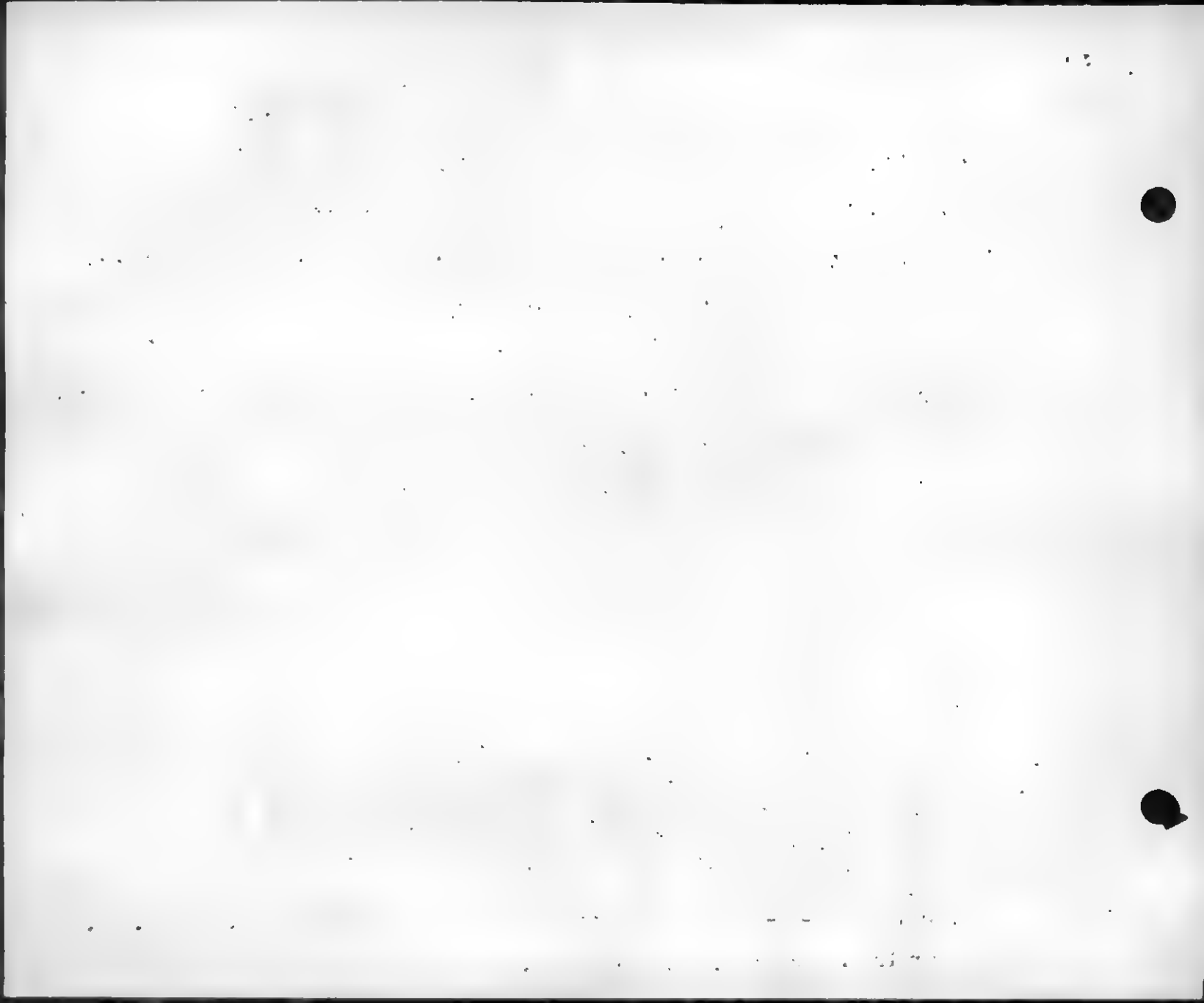
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type at print) <i>Edith Clugston Schaeffer</i>		First Middle		2a. DATE OF DEATH Month Day Year <i>March 24 1968</i>		2b. HOUR <i>7:15 P.M.</i>	
3 SEX <i>Female</i>		4. RACE <i>Cauc</i>		5 DATE OF BIRTH <i>May 18 1894</i>		6. AGE (In years last birthday) <i>73</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Chicago, Ill.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i> Md	
10 CITY OR TOWN OF DEATH <i>Rockville Md.</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Petomac Valley Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>H. wife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>Md.</i>		13b. COUNTY <i>Montg.</i>		13c. CITY OR TOWN <i>Gaithersburg</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>122 Hutton</i>		14 FATHER'S NAME First Middle Last <i>Samuel Nelson Clugston</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Agnes Porter</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. <i>217-36-6613</i>		17 INFORMANT <i>Elizabeth S. Cissel</i>		Address <i>122 Hutton Gaith.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>pneumonia</i> <i>4129</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>arterio-sclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>lost</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug 5, 1965</i> , to <i>March 23 1968</i> , that (I) (we) last saw the deceased alive on <i>March 22 1968</i> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>James L. Hooper MD</i>		DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>3/23/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>JAMES L. HOOPER MD</i>		22e. ADDRESS <i>Gaithersburg, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3-27-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Beallsville</i>		23d. LOCATION (City or town) (County) (State) <i>Beallsville Mont. Md.</i>	
24. FUNERAL DIRECTOR <i>Francis H. Barber</i>				ADDRESS <i>Laytonsville, Md.</i>		25a. REC'D BY REGISTRAR DATE: <i>MAR 27 1968</i>	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) HELEN T. SCHWIGERT			2a. DATE OF DEATH Month March Day 31 Year 1968			2b. HOUR 10 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 1/28/87		6. AGE (In years birthday) 81 YRS.	
7a. BIRTHPLACE (State or foreign country) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE D.C.		13b. COUNTY Wash.		13c. CITY OR TOWN Wash.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Albert Percy		5. MOTHER'S MAIDEN NAME First Middle Last Annie Hardy					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO 574-09-9906		17. INFORMANT Address Emily Cronin daughter - Same			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Infection DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardio Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs Mar 19 - 68 2-1963
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cerebral Thrombosis - 1963							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Mar 19, 1963 , to Mar 31, 1968 , that (I) (we) last saw the deceased alive on Mar 31, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE James E. Nolan				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Mar 31 - 1968	
22d. PHYSICIAN'S NAME (Type) JAMES E. NOLAN				22e. ADDRESS 5401 Western Ave NW Wash DC			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4/3/68		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT. CEM.		23d. LOCATION (City or Town) (County) (State) ARLINGTON, VA.	
24. FUNERAL DIRECTOR JOSEPH GUNLAW'S SONS				ADDRESS 5130 WISCONSIN AVE, NW		25a. REC'D BY REGISTRAR Charles Judge	
				DATE APR 5 - 1968		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

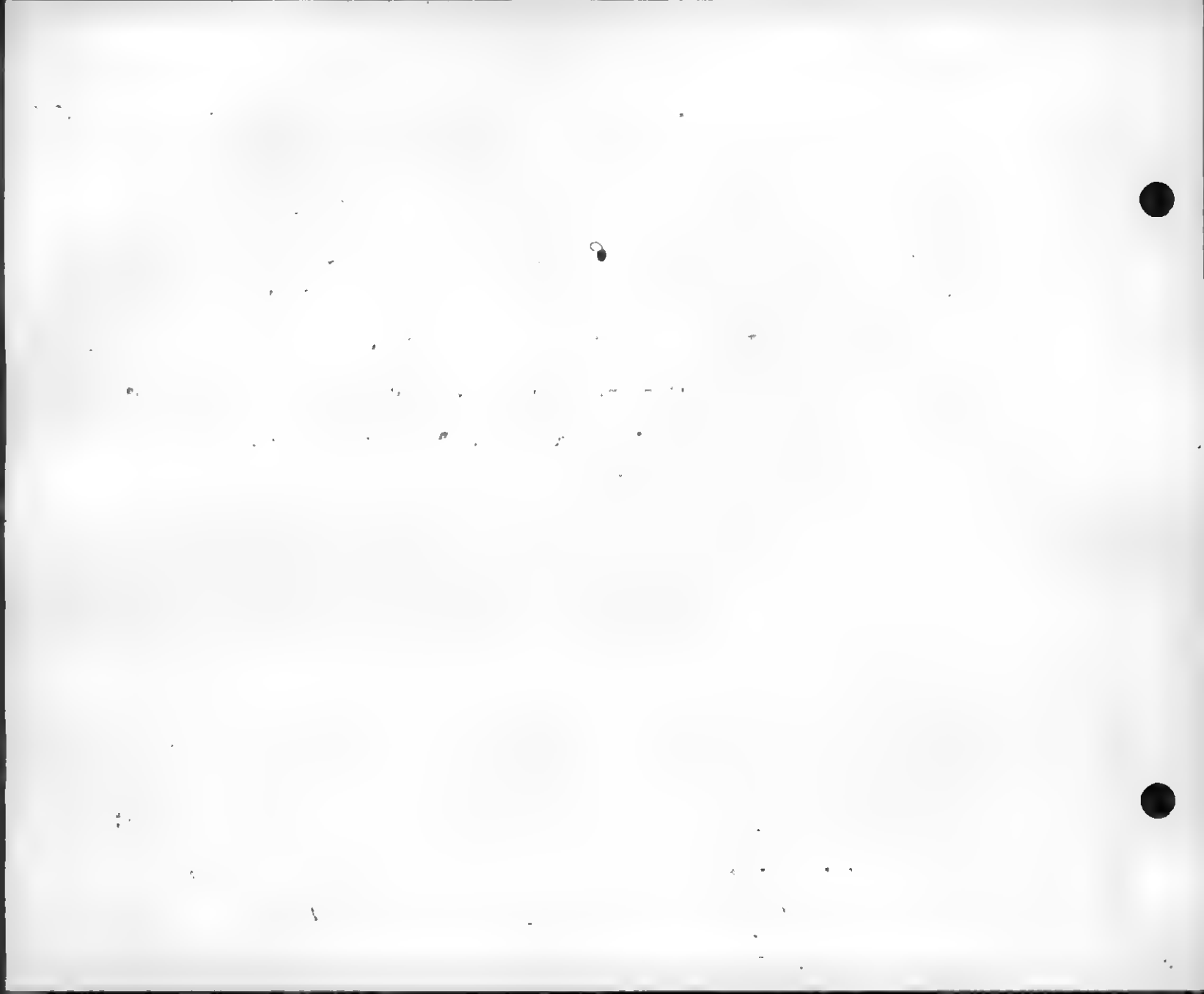
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item 6 Film G399 3/27/68 kk									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
JAMES P. SEDINGER 5						Month Day Year MARCH 15 68			6:35 PM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. UNDER 1 YEAR
MALE		CAUC		2 APR 20			46 47 YRS.		MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
PENNA		USA					MONTGOMERY Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
BETHESDA			NAVAL HOSPITAL			USMC			USMC
13a. USUAL RESIDENCE (Where deceased lived, if institution-Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
PENNA					HELLAM		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		459 FITZPATRICK LANE
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
ALVIN JOHN SEDINGER			CARRIE BYRNE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
YES			SEP 40 - SEP 60		ROSE M. SEDINGER 459 FITZPATRICK LANE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BROCHOGENIC CARCINOMA WITH SPREAD METASTASIS 16211 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 22 NOV 19 67, to 15 MAR 19 68, that (we) last saw the deceased alive on 15 MARCH 19 68 and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (we) (we) view the body after death.									
22b. SIGNATURE C. S. CRUMMY, LT, MC, USN								22c. DATE SIGNED 16 MARCH 1968	
22d. PHYSICIAN'S NAME (Type) C.S. CRUMMY, LT, MC, USN								22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			3/19/68		Arlington Nat'l Cemetery		Arlington, Virginia		
24. FUNERAL DIRECTOR C. M. Tranel					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Murphy Funeral Home, Arl., Virginia 22204							MAR 20 1968		Charles Judge



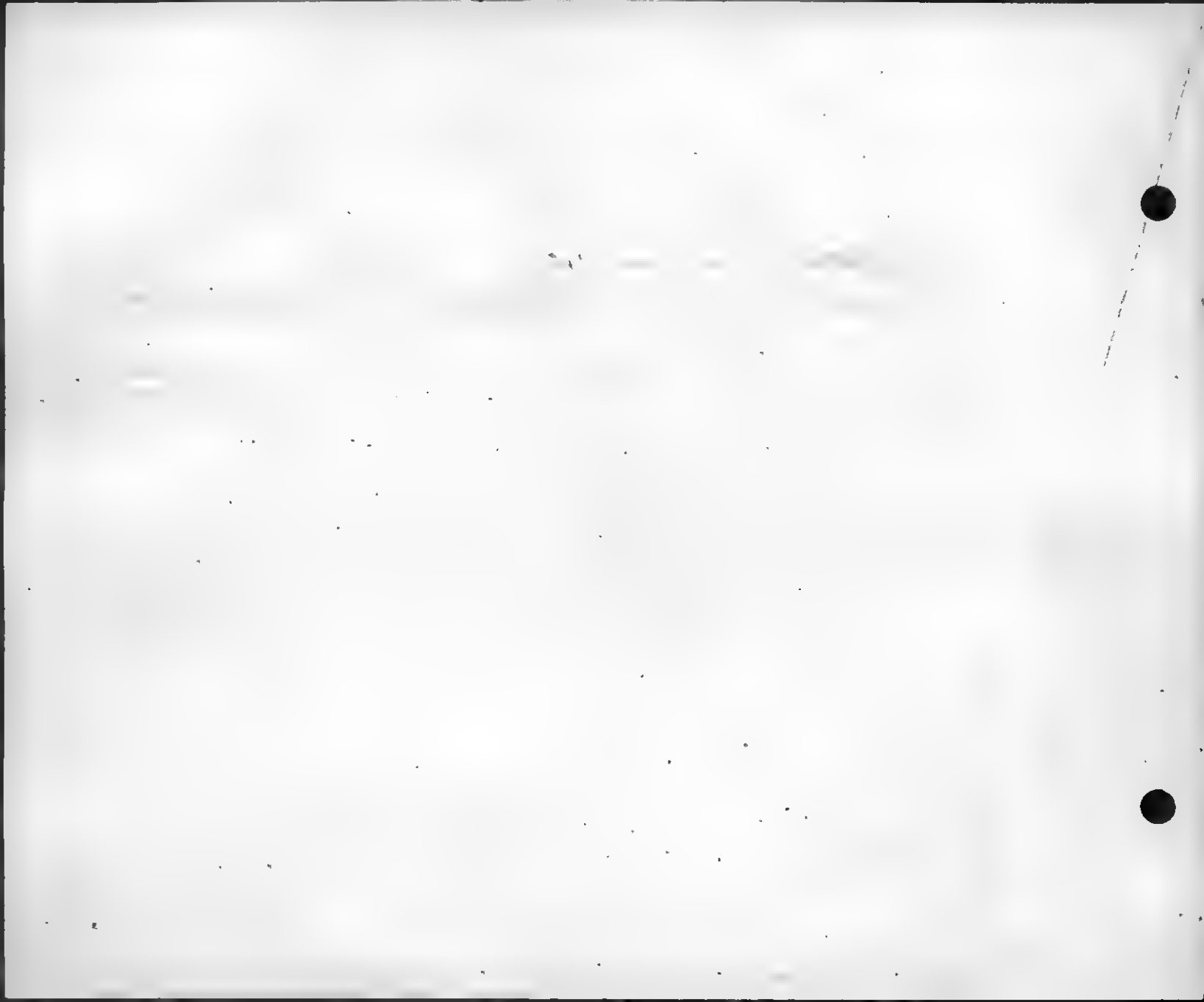
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VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) ESTHER Louise SEEBODE			2a. DATE OF DEATH Month 3 Day 8 Year 68			2b. HOUR 8:45 PM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH 7-23-99		6. AGE (in years last birthday) 68 YRS.				
7a. BIRTHPLACE (State or foreign country) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md				
10. CITY OR TOWN OF DEATH SILVER SPRING			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md			13b. COUNTY MONT.		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY & MISS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
14. FATHER'S NAME First Middle Last Joseph J. Waldron			15. MOTHER'S MAIDEN NAME First Middle Last Bertha L. Erdmann			16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give war or dates of service)				
17. INFORMANT Mrs. Mark L. Cunningham			18. ADDRESS 401 Do Horn St. Silver Spring, Md.			19. SOCIAL SECURITY NO. 578-09-1352 B				
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRO VASCULAR ACCIDENT 4339 DUE TO, OR AS A CONSEQUENCE OF (b) THROMBOSIS OF BASILAR ARTERY DUE TO, OR AS A CONSEQUENCE OF (c) CEREBRAL ATHEROSCLEROSIS							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 30 HOURS 30 HOURS UNKNOWN			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ESSENTIAL HYPERTENSION										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 1957 to MARCH 8, 1968 , that (I) (we) last saw the deceased alive on MARCH 8, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Edward G. Beeman MD						22c. DATE SIGNED MARCH 8, 1968		22d. PHYSICIAN'S NAME (Type) EDWARD A. BEEMAN MD		
22e. ADDRESS 1015 SPRING ST. SILVER SPRING, MD 20910						22f. DATE MAR 13 1968		22g. REGISTRAR'S SIGNATURE Charles J. Jones		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE March 12, 1968			23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery			23d. LOCATION (City or Town) (County) (State) Prince George County, Md.	
24. FUNERAL DIRECTOR Harner E. Pumphrey, Inc. Silver Spring, Md.						25a. REC'D BY REGISTRAR MAR 13 1968		25b. REGISTRAR'S SIGNATURE Charles J. Jones		

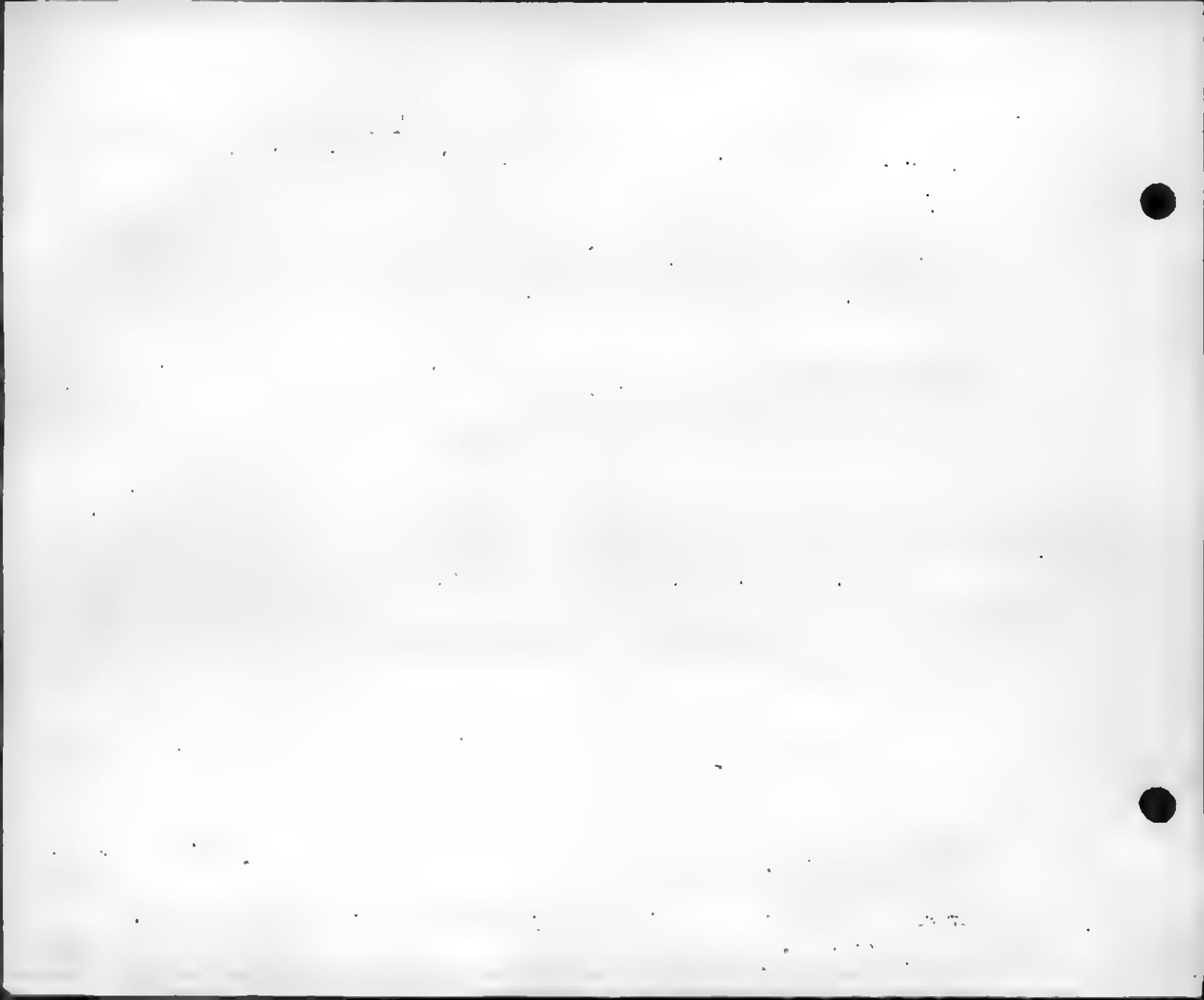


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and detach page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4453
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Sadie			First Middle Last			2a. DATE OF DEATH MARCH 27 1968			2b. HOUR 245 P M		
3. SEX Female			4. RACE W			5. DATE OF BIRTH 9-9-96			6. AGE (In years last birthday) 71 3/4 YRS.		
7a. BIRTHPLACE (State or foreign country) Penn.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md		
10. CITY OR TOWN OF DEATH Wheaton			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Randolph Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Penn.			13b. COUNTY L			13c. CITY OR TOWN ORWIGSBURG			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 408 NORTH WARREN			14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give year or dates of service)			16b. SOCIAL SECURITY NO 160-05-6971-A			17. INFORMANT MR FRANCIS SELTZER			Address 209 Holton Ln TAKOMA PARK MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 1129 DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY EMBOLUS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 4341 (c) CHRONIC CONGESTIVE HEART FAILURE Months									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CORONARY DISEASE MITRAL STENOSIS CIRC											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN DETERMINING CAUSES OF DEATH? cardiac vascular cerebral embolus		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1-30 , 1968, to 3-27 , 1968, that (I) (we) last saw the deceased alive on 3-27 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John L Ford			DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 3/27/68					
22d. PHYSICIAN'S NAME (Type) JOHN L. FORD			22e. ADDRESS 831 UNIVERSITY BLVD E SILVER SPRING, MD								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 3/30/68			23c. NAME OF CEMETERY OR CREMATORY Salem Evangelical Cemetery Orwigsburg, Penna.			23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland						25a. REC'D BY REGISTRAR POP 1			25b. REGISTRAR'S SIGNATURE Charles Judge		



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last Albert N. Senseney			2a. DATE OF DEATH Month Day Year March 22 1968		2b. HOUR 9:30 ^A
3. SEX Male	4. RACE White	5. DATE OF BIRTH Aug. 18, 1891		6. AGE (in years last birthday) 76 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md
10. CITY OR TOWN OF DEATH Damascus		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 9805 Sugarloaf Dr.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Inspector- State of Maryland	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Damascus	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 9805 Sugarloaf Dr.
14. FATHER'S NAME First Middle Last Charles A. Senseney			15. MOTHER'S MAIDEN NAME First Middle Last Emma M. Davidson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) Yes		16b. SOCIAL SECURITY NO. 212-24-4407		17. INFORMANT Address Mrs Mamie O. Senseney, Damascus, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Pneumonia 17X DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Fibrosis and Emphysema DUE TO, OR AS A CONSEQUENCE OF (c) Lymphoma of hilar nodes about 5 years ago treated with radiation. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Lymphoma of hilar nodes about 5 years ago treated with radiation.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours 10 yrs.
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1955 to Mar 22 , 19 68 , that (I) (we) last saw the deceased alive on March 22 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Gilcin F. Meadors</i> M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED Mar 23, 1968	
22d. PHYSICIAN'S NAME (Type) Gilcin F. Meadors, M.D.				22e. ADDRESS 810 Toll House Ave. Frederick Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 25, 1968		23c. NAME OF CEMETERY OR CREMATORY Montgomery Meth.	
23d. LOCATION (City or Town) (County) (State) Clagettville, Md.					
24. FUNERAL DIRECTOR ADDRESS Olin L. Molesworth, Damascus, Md.			25a. REC'D BY REGISTRAR MAR 26 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

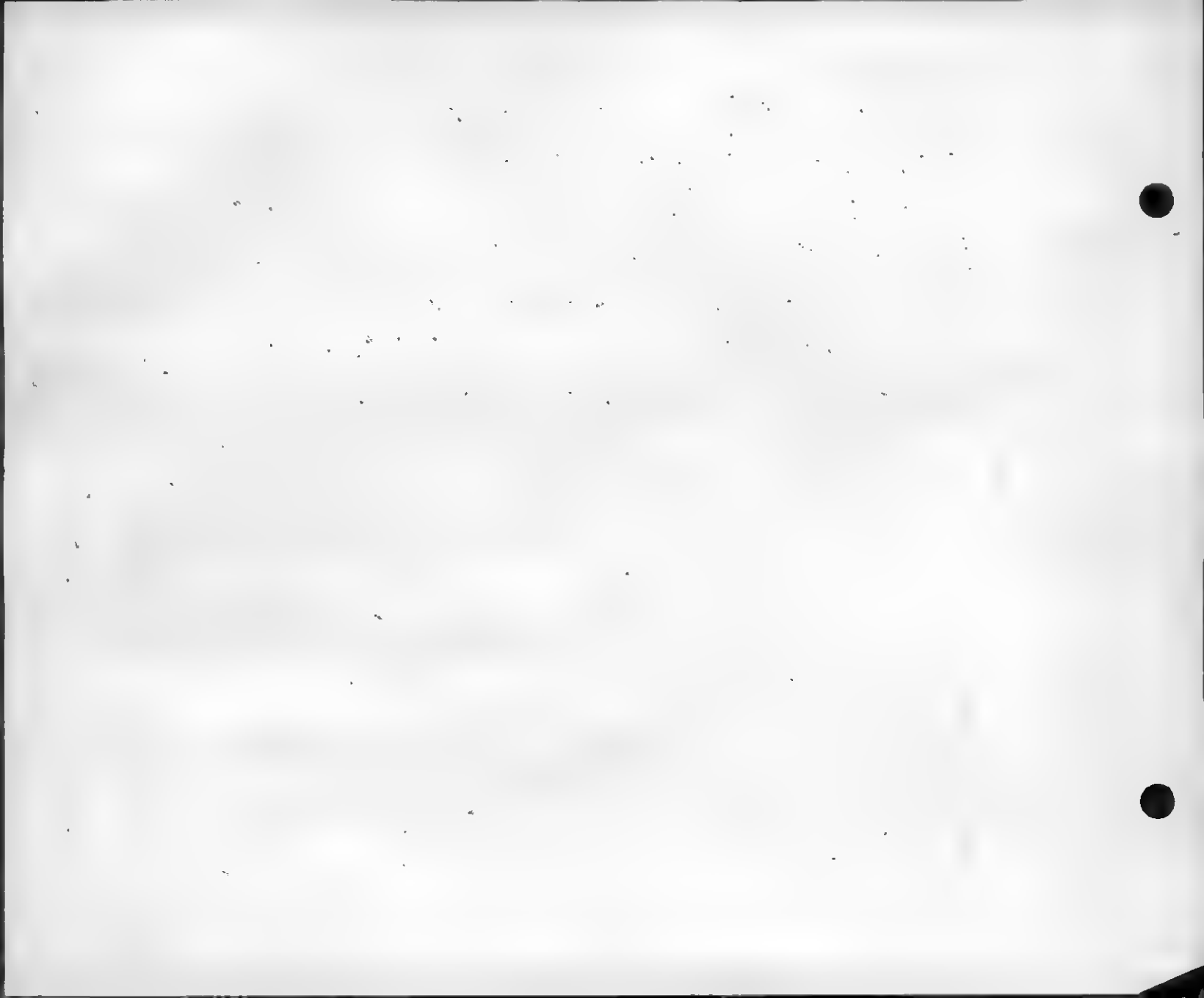


CERTIFICATE OF DEATH

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1 DECEASED NAME (Type or print) MAUDE First LEYBERT Middle LEYBERT Last		2a DATE OF DEATH Month 3 Day 10 Year 68		2b HOUR 7:30 AM
3 SEX FEMALE	4 RACE CAUCASIAN	5. DATE OF BIRTH 30 DEC. 1875	6 AGE (n years last birthday) 92 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (State or foreign country) PENNA.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH MONTGOMERY Md	
10 CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) RESMOR	12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD	13b COUNTY MONT	13c CITY OR TOWN SILVER SPRING	13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e STREET AND NUMBER
14 FATHER'S NAME First UNKNOWN Middle UNKNOWN Last UNKNOWN		15 MOTHER'S MAIDEN NAME First UNKNOWN Middle UNKNOWN Last UNKNOWN		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown		16b SOCIAL SECURITY NO 263 76 1832	17 INFORMANT Address David L. SEYBERT 3557 South	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CIRCULATORY COLLAPSE 129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) ARTERIO SCLEROTIC HEART D. DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIO SCLEROSIS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH > 1 hr > 10 yrs > 15 yrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 42. CHRONIC BRONCHITIS SYNDROME, MULTIPLE SMALL STROKE				
19a DATE OF OPERATION 0	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 0	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? D.N.A.	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. 11 P.M. 11 Month 11 Day 11 Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) D. H. H.		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) D. H. H.	21f LOCATION Street or R.F.D. No D. H. H. City or Town D. H. H. County D. H. H. State D. H. H.		
22a I certify that (I) (this hospital) attended the deceased from Nov 11, 1967 to March 10, 1968 , that (I) (we) last saw the deceased alive on 3/8 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b SIGNATURE Charles Savanese, M.D. DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c DATE SIGNED 3/11/68	
22d. PHYSICIAN'S NAME (Type) CHARLES SAVANESE, M.D.		22e ADDRESS 11125 ROCKVILLE PIKE ROCKVILLE, MARYLAND		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE 3-13-68	23c NAME OF CEMETERY OR CREMATORY Cowansville Cem.	23d LOCATION (City or Town) Cowansville, Pa.	(County) Pa. (State)
24. FUNERAL DIRECTOR Lee Funeral Home		ADDRESS Washington, D.C.		25a REC'D BY REGISTRAR MAR 12 1968

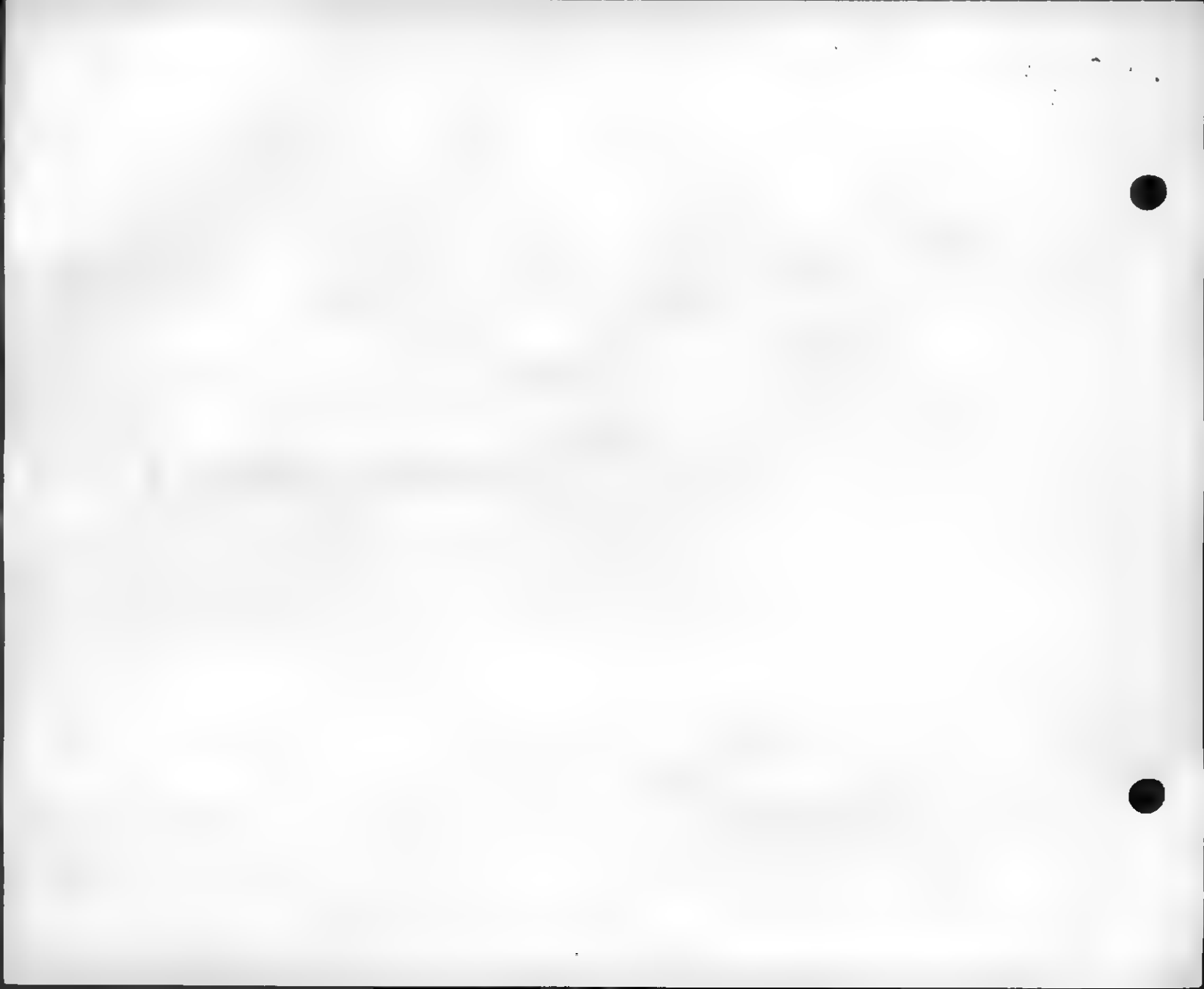


CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <i>Mary Agatha Sheehan</i>			2a. DATE OF DEATH Month <i>March</i> Day <i>20</i> Year <i>1968</i>			2b. HOUR <i>4:45 PM</i>	
3 SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Dec 9, 1876</i>		6 AGE (in years lost birthday) <i>91</i> YRS.	
7a BIRTHPLACE (State or foreign country) <i>Mass.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md	
10 CITY OR TOWN OF DEATH <i>Bethesda area</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>7505 Ben avon Road</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Home</i>		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <i>Md</i>		13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Bethesda</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e STREET AND NUMBER <i>7505 Road</i>		13f CITY, STATE, AND ZIP CODE <i>Bethesda, Md 20814</i>		13g ADDRESS <i>Ben avon Road</i>			
14 FATHER'S NAME First <i>John</i> Middle <i>F.</i> Last <i>Maloney</i>			15 MOTHER'S MAIDEN NAME First <i>Margaret</i> Middle <i>E.</i> Last <i>Daley</i>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b SOCIAL SECURITY NO. (If yes give war or dates of service) <i>215-48-71071</i>		17 INFORMANT <i>daughter</i>		Address <i>same as above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY <i>433.9</i> IMMEDIATE CAUSE (a) <i>Cachexia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral arteriosclerosis + thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>gradual - weeks</i> <i>16 months</i> <i>years</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <i>330</i>							
19a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>August 5, 1958</i> to <i>March 19, 1968</i> , that (I) (we) last saw the deceased alive on <i>March 19, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Allen J. O'Neill MD</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>March 20, 1968</i>	
22d. PHYSICIAN'S NAME (Type) <i>Allen J. O'Neill, MD</i>				22e. ADDRESS <i>8601 Old Georgetown Rd, Bethesda Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3-25-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Bridget's Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Easthampton, Mass.</i>	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>				25a. REC'D BY REGISTRAR DATE <i>MAR 26 1968</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION



CERTIFICATE OF DEATH

4448

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) <u>John</u> First <u>Augustus</u> Middle <u>Simpson</u> Last		2a. DATE OF DEATH Month <u>Mar</u> Day <u>7</u> Year <u>1968</u>		2b. HOUR <u>3:45</u> P.M.	
3 SEX <u>male</u>	4. RACE <u>white</u>	5 DATE OF BIRTH <u>12/22/1907</u>	6. AGE (In years lost birthday) <u>65</u> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <u>Montgomery</u> Md.		
10. CITY OR TOWN OF DEATH <u>Bethesda</u>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Seaboard Hospital</u>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Manufacturing Representative</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>Dairy</u>		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) <u>Maryland</u> STATE	13b. CITY OR TOWN <u>Montgomery</u>	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET AND NUMBER <u>800 Dorset Ave</u>		
14 FATHER'S NAME First <u>William</u> Middle <u>Aubrey</u> Last <u>Simpson</u>	15. MOTHER'S M.A.D.E.N. NAME First <u>Elizabeth</u> Middle <u>Kuhnert</u> Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16b. SOCIAL SECURITY NO. <u>577-07-472</u>	17. INFORMANT <u>Jane Simpson (wife)</u> Address <u>add same</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u>					<u>1 hour</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Coronary Thrombosis</u>					<u>1 hour</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery disease</u>					<u>years</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>4201</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR <u>A.M.</u> Month <u>Oct</u> Day <u>7</u> Year <u>1968</u>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or RFD No	City or Town	County	State
22a. I certify that () (this hospital) attended the deceased from <u>Oct 7</u> , 19 <u>67</u> , to <u>3/7</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Feb 24</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Thomas E. Curtin MD</u>		DEGREE	ATTENDING PHYS.	MED DIRECTOR	STAFF PHYS.
22d. PHYSICIAN'S NAME (Type) <u>Dr. Thomas E. Curtin</u>		22e. ADDRESS <u>4600 Connecticut Ave N.W. Wash D.C.</u>		22c. DATE SIGNED <u>3/7/68</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3-9-1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	23d. LOCATION (City or Town) <u>Washington, D.C.</u>	(County) (State)	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> <u>5130 Wisc. Ave. N.W. Wash. D.C.</u>		25a. REC'D BY REGISTRAR <u>MAR 13 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



1

44483

MD

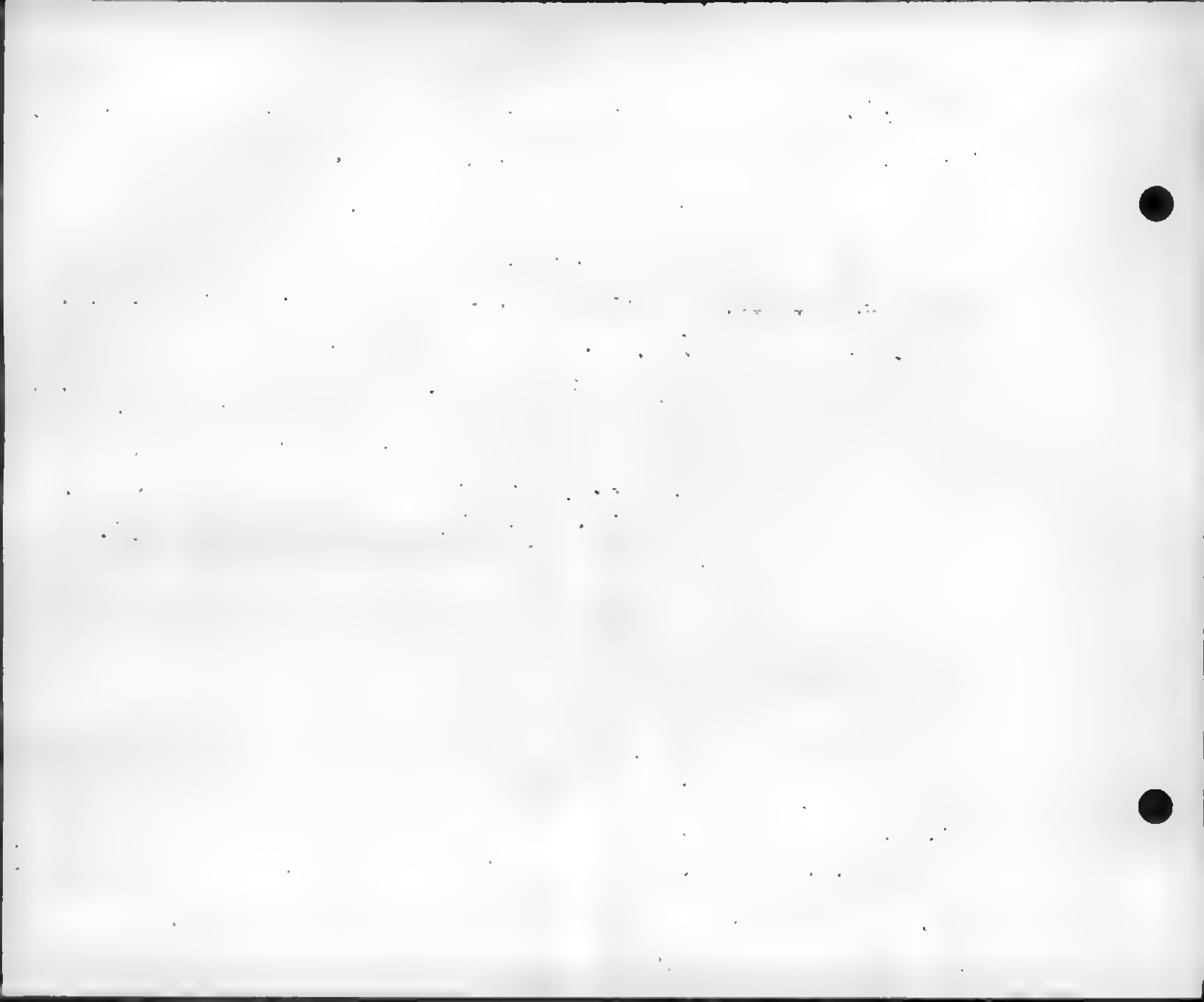
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Violet</i> First Middle Last			2a. DATE OF DEATH Month <i>3</i> Day <i>5</i> Year <i>1968</i>			2b. HOUR <i>1:15</i> P. M.	
3. SEX <i>female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>9/30/1902</i>		6. AGE (In years lost birthday) <i>65</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Guadalupe</i>		7b. CIT ZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery Co.</i> Md	
10. CITY OR TOWN OF DEATH <i>Kensington, Ind.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Kensington Gardens Sanatorium</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>none</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>Ind.</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Washington, D.C.</i>		13d. INSIDE CITY LMA TSP YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>1611 Park Rd.</i>		14. FATHER'S NAME First Middle Last <i>James Henry Sigemore</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Unobtainable</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO <i>579-50 4199</i>		17. INFORMANT <i>John H. Shouse</i>		Address <i>3806 Veazey St. N.W.</i>		City <i>Washington, D.C.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>congestive heart failure</i> (b) <i>aortic stenosis</i> (c) <i>(probable) Rheumatic Heart Dis.</i>							
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION <i>4/1/68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>7-24, 1964</i> to <i>3-5, 1968</i> , that (I) was last saw the deceased alive on <i>3-4, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death.							
22b. SIGNATURE <i>D.P. Sengstack M.D.</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>3-5-68</i>	
22b. PHYSICIAN'S NAME (Type) <i>G.F. Sengstack</i>				22c. ADDRESS <i>9241 Columbia Blvd. Silver Spring, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>3/7/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Suitland, Md.</i>	
24. FUNERAL DIRECTOR <i>The H. Hine Co.</i>				ADDRESS <i>2901 14th ST. N.W.</i>		25a. REC'D BY REGISTRAR DATE <i>MAR 8 1968</i>	
				25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



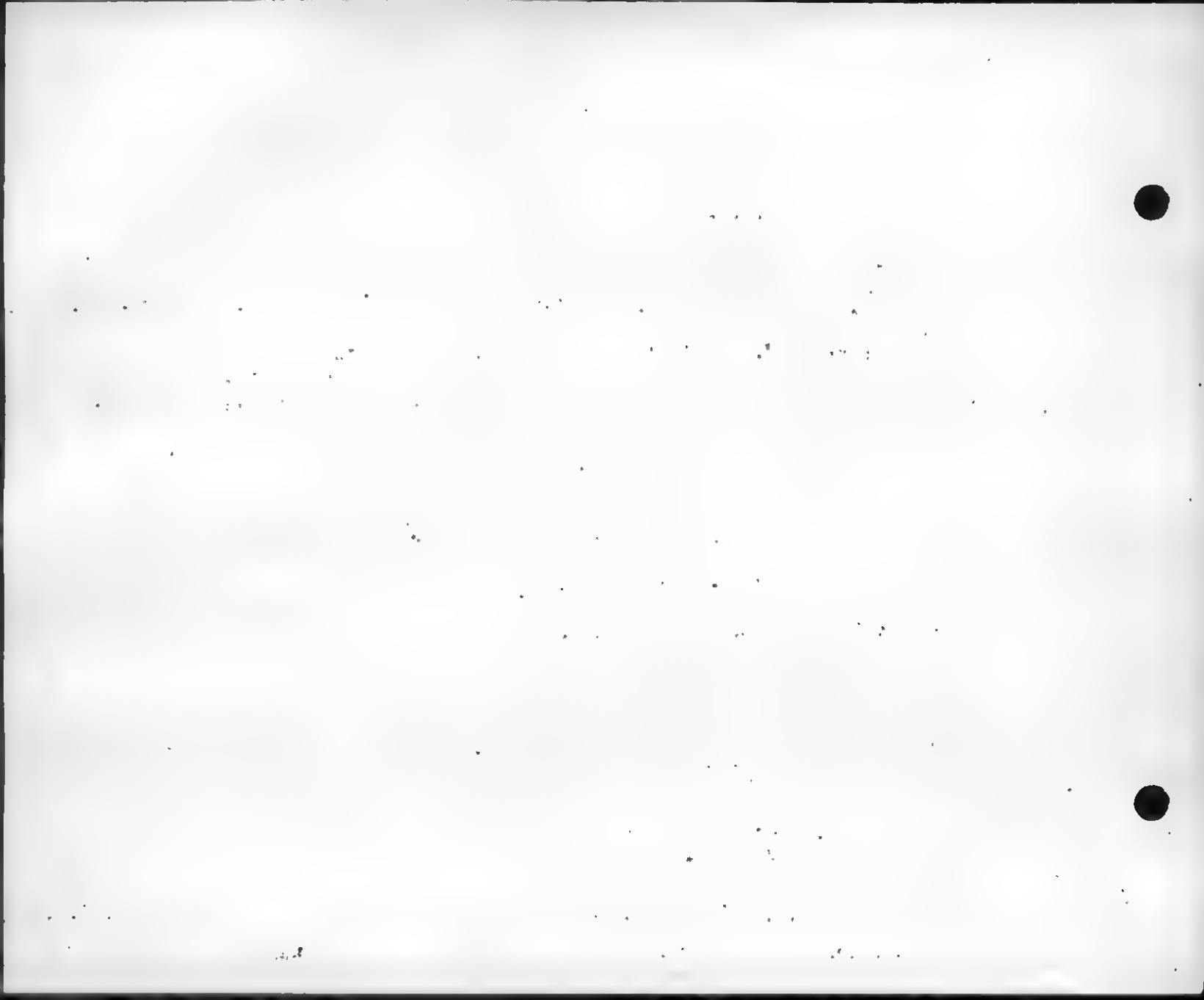
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) EDWIN LEVELLE SKIDMORE			2a. DATE OF DEATH Month 03 Day 02 Year 68			2b. HOUR 11:23 AM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH 7/1/03		6. AGE (In years lost birthday) 64 YRS.		7. UNDER 1 YEAR MONTHS 00 DAYS 00 HOURS 00 MIN.	
7a. BIRTHPLACE (State or foreign country) New Jersey	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Paper	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Montg.	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 3561 S. Leisure Wld. Blvd.		
14. FATHER'S NAME First Middle Last Frank H. Skidmore			15. MOTHER'S MAIDEN NAME First Middle Last Anna Cavanus				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Medical Records dept. of Montg. General Hospt., Olney, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pulmonary embolism 4/1/1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4/20/1 (b) acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic heart disease 1 hr 1 year							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Transitional cell carcinoma of bladder							
19a. DATE OF OPERATION 11/23/67		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of bladder		20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from May 15, 1967 to March 2, 1968 , that (I) (we) last saw the deceased alive on March 1, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE John P. Maylath, MD		DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 3/3/68	
22d. PHYSICIAN'S NAME (Type) JOHN P. MAYLATH		22e. ADDRESS 50 W. EDMONDSON DR. ROCKVILLE, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Mar. 5, 1968		23c. NAME OF CEMETERY OR CREMATORY St. Johns		23d. LOCATION (City or Town) (County) (State) Queens Co., Long Island, N.Y.	
24. FUNERAL DIRECTOR Harry H. Witzke, Columbia Pk., Ellicott City, Md.				25a. REC'D BY REGISTRAR DATE 4 1968		25b. REGISTRAR'S SIGNATURE William J. Judge	



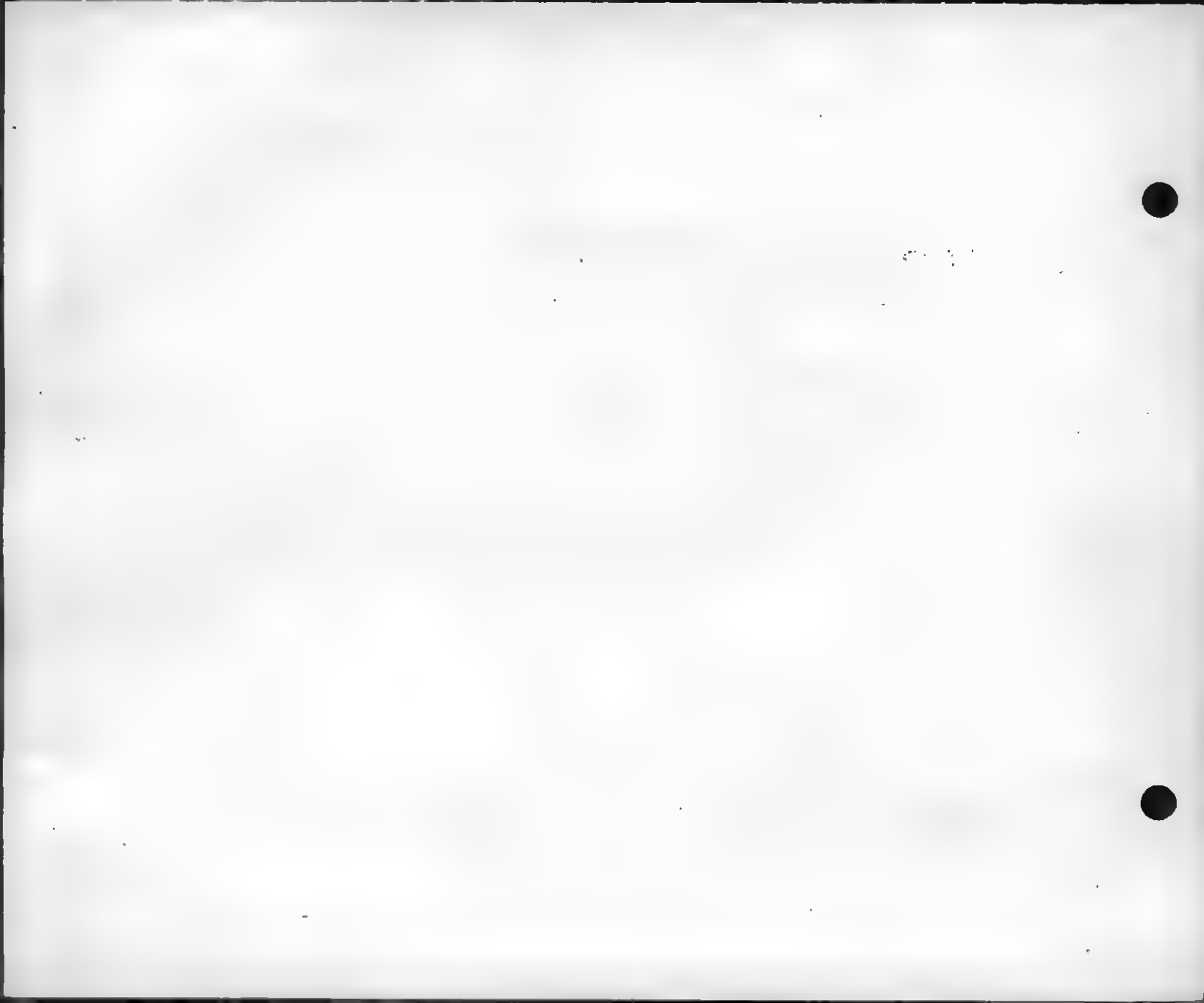
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print) DANIEL (NONE) SMITH			First Middle Last			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year March 11 1968			2b. HOUR 5:10 PM		
3 SEX Male	4 RACE NEGRO	5 DATE OF BIRTH 1-17-17	6 AGE (in years last birthday) 51 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month 3 Day 11 Year 1968			2d. HOUR 5:10 PM		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery					
10 CITY OR TOWN OF DEATH Takoma Park			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Wash. San. & Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.			13b. COUNTY Highville			13c. CITY OR TOWN So. Md. Correctional Cam			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Artery Insufficiency Acute DUE TO, OR AS A CONSEQUENCE OF (b) Cardio Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden Years		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John B. Ball EXAMINER'S NAME (Type)						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)			22b. DATE SIGNED March 12, 1968		
23a. BURIAL (CREMATION) (Specify)			23b. DATE 3-19-68			23c. NAME OF CEMETERY OR CREMATORY U.S. Md. Med School			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR DATE MAR 21 1968			25b. REGISTRAR'S SIGNATURE William J. Judge		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-105. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) ETHEL M. SMITH		First Middle Last		2a DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year MARCH 1 1968		2b HOUR 1:35 P.M.	
3 SEX F	4 RACE W	5 DATE OF BIRTH 6-4-1894	6 AGE (In years lost birthday) 73 YRS	7 IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	7 IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c DATE PRONOUNCED DEAD March 1 1968	
7a BIRTHPLACE (State or foreign country) Bedford PA		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery	
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban		12a U.S. OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD -		13b COUNTY Montgomery		13c CITY OR TOWN Rockville		3d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME Henry W. COGAN		First Middle Last		15 MOTHER'S MAIDEN NAME Rebecca Bowser		First Middle Last	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b SOCIAL SECURITY NO		17 INFORMANT Son - James A Smith		ADDRESS Spring Hill - Md. 5427 7th Avenue Rd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolism - Massive - 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cardiovascular Disease - DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs. years.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f LOCATION Street or R.F.D. No. City or Town County State			
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John G. Ball		EXAMINER'S NAME (Type) John G. Ball		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED March 1, 1968	
23a BURIAL, CREMATION REMOVAL (Specify) burial		23b DATE 3/5/68		23c NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d LOCATION (City or Town) (County) (State) Washington, L.C.	
24 FUNERAL DIRECTOR The S. Hines Co. ADDRESS 2901 14th St. N.W. Washington, D.C.				25a REC'D BY REG. STR. MAR 5 1968		25b REG. STR.'S SIGNATURE Charles J. Jones	

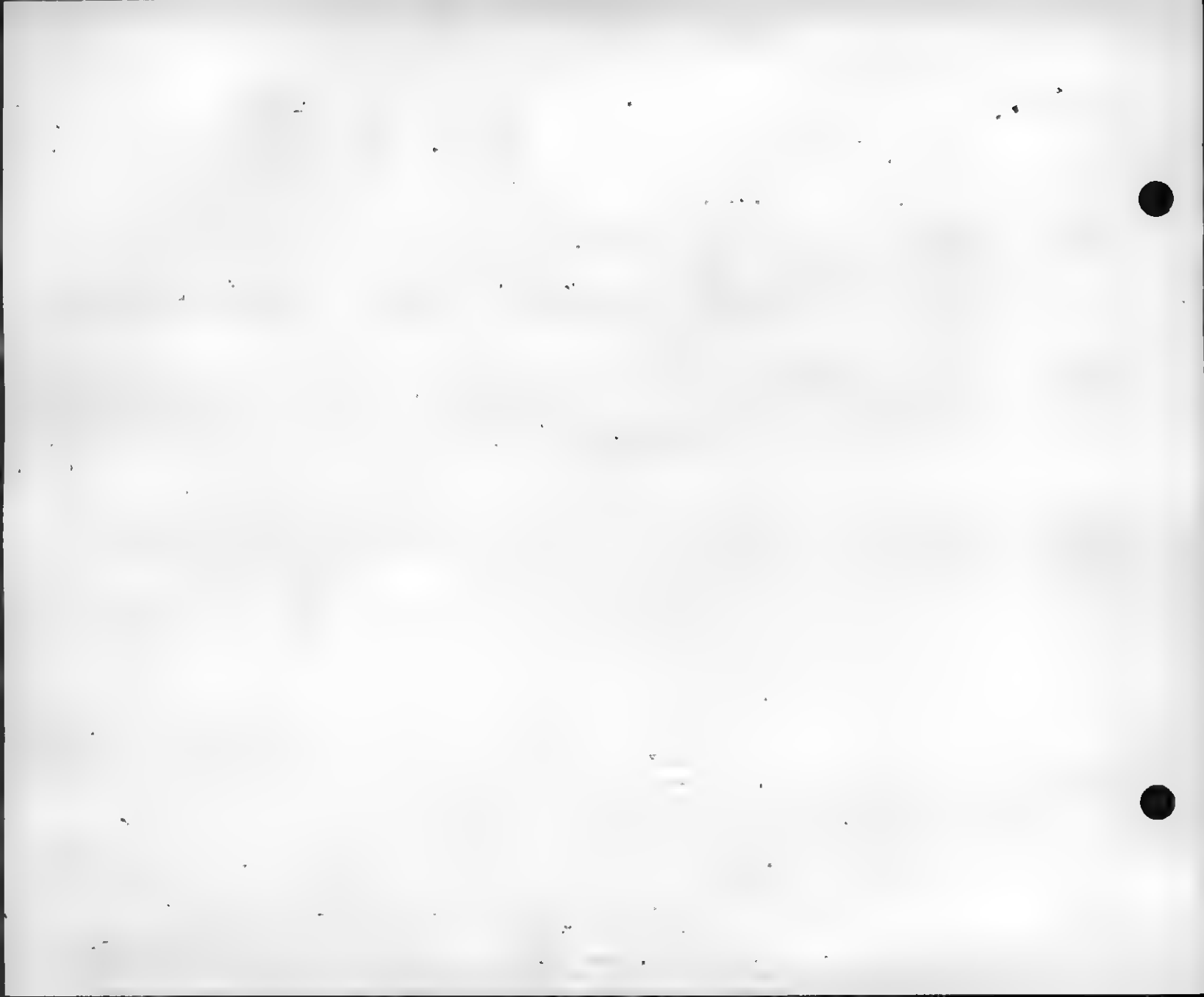


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Fern		First R.		Middle Smith		Last		2a. DATE OF DEATH Month March Day 4 Year 1968		2b. HOUR 3:50 AM	
3 SEX Female		4 RACE White		5. DATE OF BIRTH 2/28/1910		6 AGE (In years last birthday) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN 	
7a. BIRTHPLACE (State or foreign country) Oklahoma		7b. CIT ZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bldg. 263 Apt 707		12a. USUAL OCCUPATION (Kind of work done during most of work no. life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) ST Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Bldg 263 Apt 707 Congressional Lane			
14. FATHER'S NAME Elihy		First		Middle Bonewell		Last		15. MOTHER'S MAIDEN NAME Agnes		First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown <input type="checkbox"/>		16b. SOCIAL SECURITY NO		17 INFORMANT Gerald N. Smith-husband-same item # 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized Coronary DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Jan , 19 67 , to March , 19 68 , that (I) (we) last saw the deceased alive on Feb 26 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE James W. Egan		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED <input type="checkbox"/> STAFF <input type="checkbox"/>		22c. DATE SIGNED 3/4/68					
22d. PHYSICIAN'S NAME (Type) James W. Egan		22e. ADDRESS 7720 Wisconsin Ave., Bethesda, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3/6/68		23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City or Town) (County) (State) Oklahoma, Oklahoma, Okla.					
24. FUNERAL DIRECTOR Tyson Wheeler		1331 Rockville Pike Rockville, Md. 20852		25a. REC'D BY REGISTRAR DEAR 5 1968		25b. REGISTRAR'S SIGNATURE [Signature]					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

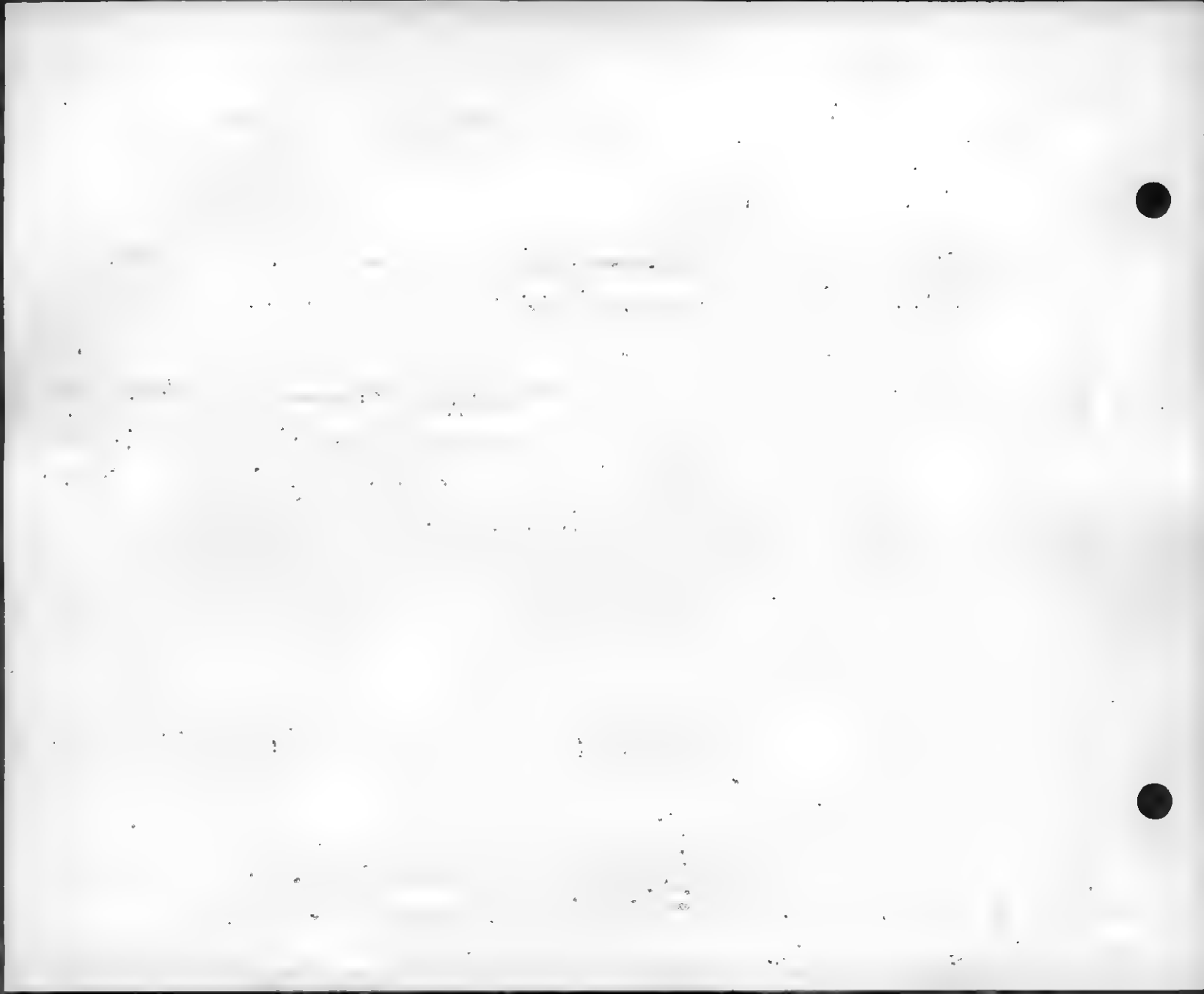
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last Mabel C Smith			2a. DATE OF DEATH Month Day Year Mar. 17 1968			2b. HOUR 7 ⁰⁰ A M	
3 SEX Female		4 RACE White		5. DATE OF BIRTH Nov. 24 - 1880		6. AGE (In years last birthday) 87 YRS.	
7a. BIRTHPLACE (State or foreign country) Michigan		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Booke Gorge Foundation		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) School Teacher		12b. KIND OF BUSINESS OR INDUSTRY School	
13a. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE 309 Bradley Ave.		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 309 Bradley Ave.		13f. CITY OR TOWN Rockville Md.					
14. FATHER'S NAME First Middle Last William C Smith			15. MOTHER'S MAIDEN NAME First Middle Last Teranna C Carleton				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na (or unknown) (If yes give war or dates of service) None			16b. SOCIAL SECURITY NO. None		17. INFORMANT Mary Snyder - 309 Bradley Ave. - Rockville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive C-V Disease</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hr. 1 mo. yrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 3/14/68, to 3/17/68, that (I) (we) lost saw the deceased alive on 3/14/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.							
22b. SIGNATURE C.H. Ligon M.D.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/17/68	
22d. PHYSICIAN'S NAME (Type) C.H. Ligon M.D.		22e. ADDRESS Sandy Spring Md. 20860					
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 3-17-68		23c. NAME OF CEMETERY OR CREMATORY GEORGETOWN UNIV. MED. CN. WASHINGTON, D.C.		23d. LOCATION (City or Town) (County) (State) WASHINGTON, D.C.	
24. FUNERAL DIRECTOR James C. DeWitt-2222 Univ. Ave. Wash D.C.		ADDRESS		25a. REC'D BY REGISTRAR DATE MAR 26 1968		25b. REGISTRAR'S SIGNATURE James C. DeWitt	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

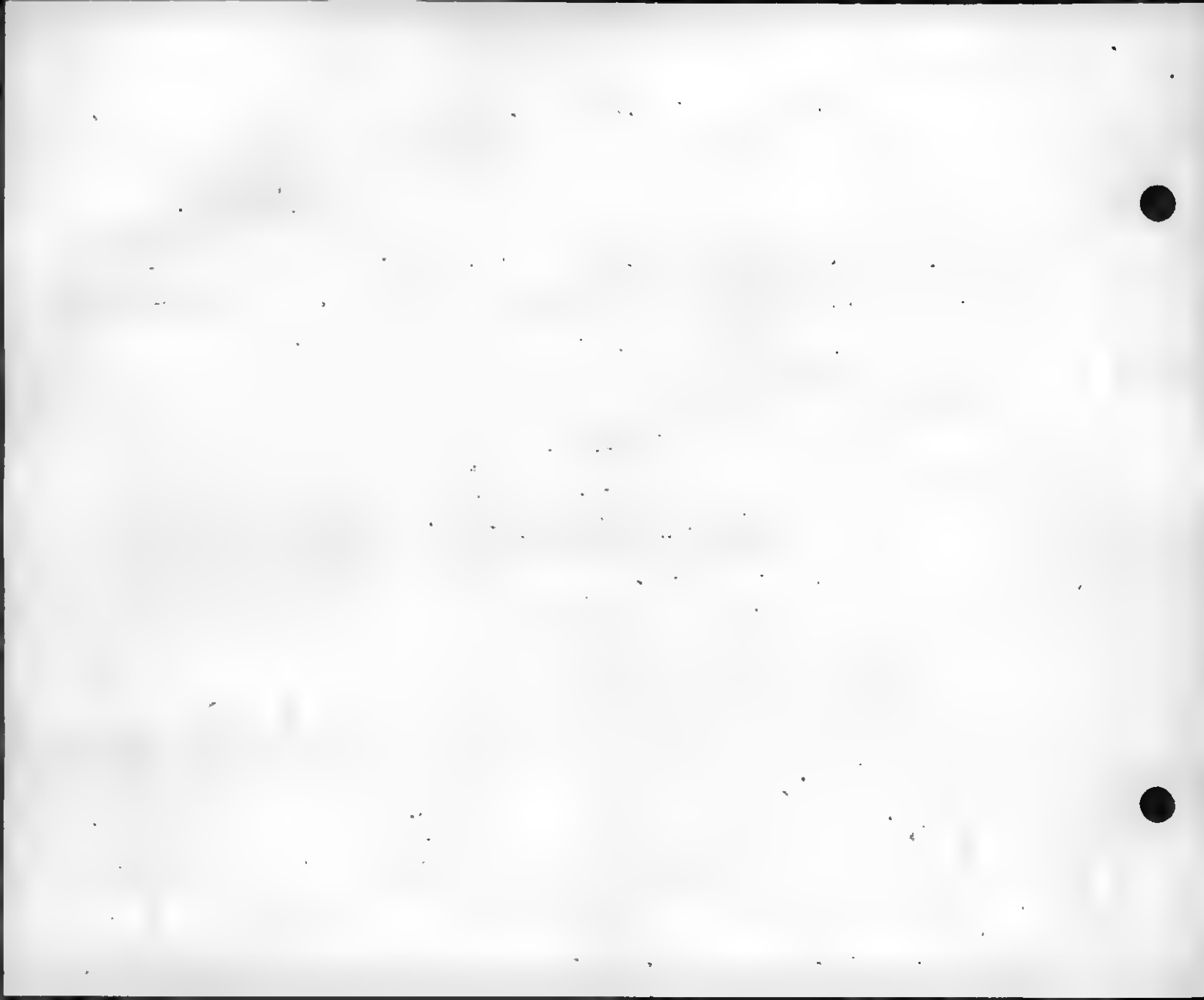
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
304A REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) LOUELLA PLUM SOMERS			2a. DATE OF DEATH Month 3 Day 21 Year 1968		2b. HOJR 40 M
3. SEX F	4. RACE white	5. DATE OF BIRTH Oct. 9-1885		6. AGE (In years last birthday) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Burlington Iowa	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md		
10. CITY OR TOWN OF DEATH Burlington Olney	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Brookings Foundation	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) statistician	12b. KIND OF BUSINESS OR INDUSTRY Gov.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Lanham Md.	13b. COUNTY Prince Georges	13c. CITY OR TOWN Lanham	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 204 Hensel Rd.	
14. FATHER'S NAME First Middle Last Rahut Wood	15. MOTHER'S MAIDEN NAME First Middle Last Louella Wood				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) no	16b. SOCIAL SECURITY NO	17. INFORMANT daughter Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infection, terminal DUE TO, OR AS A CONSEQUENCE OF infection Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last elderly & generalized arteriosclerosis (b) arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF arteriosclerosis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH several months
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) multiple bed sores Herbersons disease					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 10-10-1967 , to 3-21-1968 , that (I) (we) last saw the deceased alive on 3-18-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death <input checked="" type="checkbox"/>					
22b. SIGNATURE John R. Spencer, MD		DEGREE	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type) JOHN R SPENCER		22e. ADDRESS BURTONSVILLE MD.		22c. DATE SIGNED 3-21-68	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE March 21 1968	23c. NAME OF CEMETERY OR CREMATORY Lee Funeral Home	23d. LOCATION (City or Town) (County) (State) Washington D.C.		
24. FUNERAL DIRECTOR Francis H. Barber	ADDRESS Laytonville Md.		25a. REC'D BY REGISTRAR MAR 26 1968	25b. REGISTRAR'S SIGNATURE Charles Jones	

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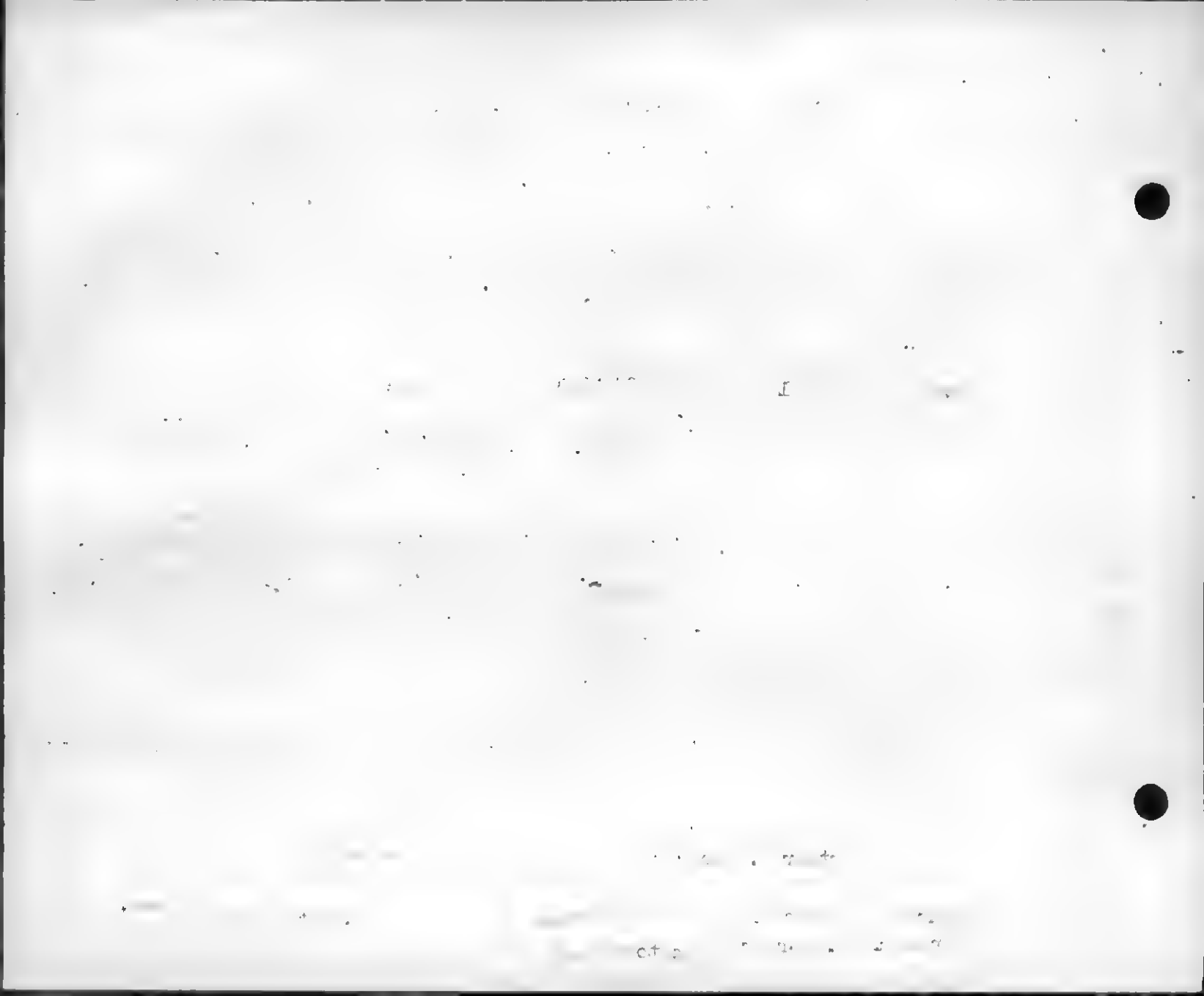


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
2260
MIDDLE
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) ELGAR		First ELGAR		Middle HALLOWELL		Last STABLER		2a. DATE OF DEATH Month 3 Day 20 Year 68			2b. HOUR 11:45		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 4-9-99				6. AGE (In years last birthday) 68 YRS		IF UNDER 1 YEAR MONTHS _____ DAYS _____ IF UNDER 24 HRS HOURS _____ MIN _____			
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.							
10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MONTGOMERY GENERAL HOSP.				2c. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED - ENGINEER			12b. KIND OF BUSINESS OR INDUSTRY CHEMICALS				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SPENCERVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1301 SPENCERVILLE ROAD					
14. FATHER'S NAME First NEWTON				Middle STABLER		Last MARY		15. MOTHER'S MAIDEN NAME First MARY				Middle HALLOWELL	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. 578 32 2384		17. INFORMANT MEDICAL RECORDS									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of liver - metastatic to liver 1978 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost also focal peritonitis, pelvis + nephros + benign (b) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Left kidney post-operative Bronchopneumonia, Pulmonary edema + pleural effusion										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mo.			
19a. DATE OF OPERATION 3/11/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of colon				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____									
22a. I certify that (I) (this hospital) attended the deceased from 3/8 , 19 68 , to 3/20 , 19 68 , that (I) (we) last saw the deceased alive on 3/20 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Arthur F. Woodward				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/21/68					
22d. PHYSICIAN'S NAME (Type) Arthur F. Woodward		22e. ADDRESS Rockville Md											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 22 1968		23c. NAME OF CEMETERY OR CREMATORY Friends		23d. LOCATION (City or Town) (County) (State) Sandy Spring Mont. Md							
24. FUNERAL DIRECTOR Francis H. Barber		ADDRESS Laytonsville Md		25a. REC'D BY REGISTRAR MAR 26 1968		25b. REGISTRAR'S SIGNATURE James E. Young							



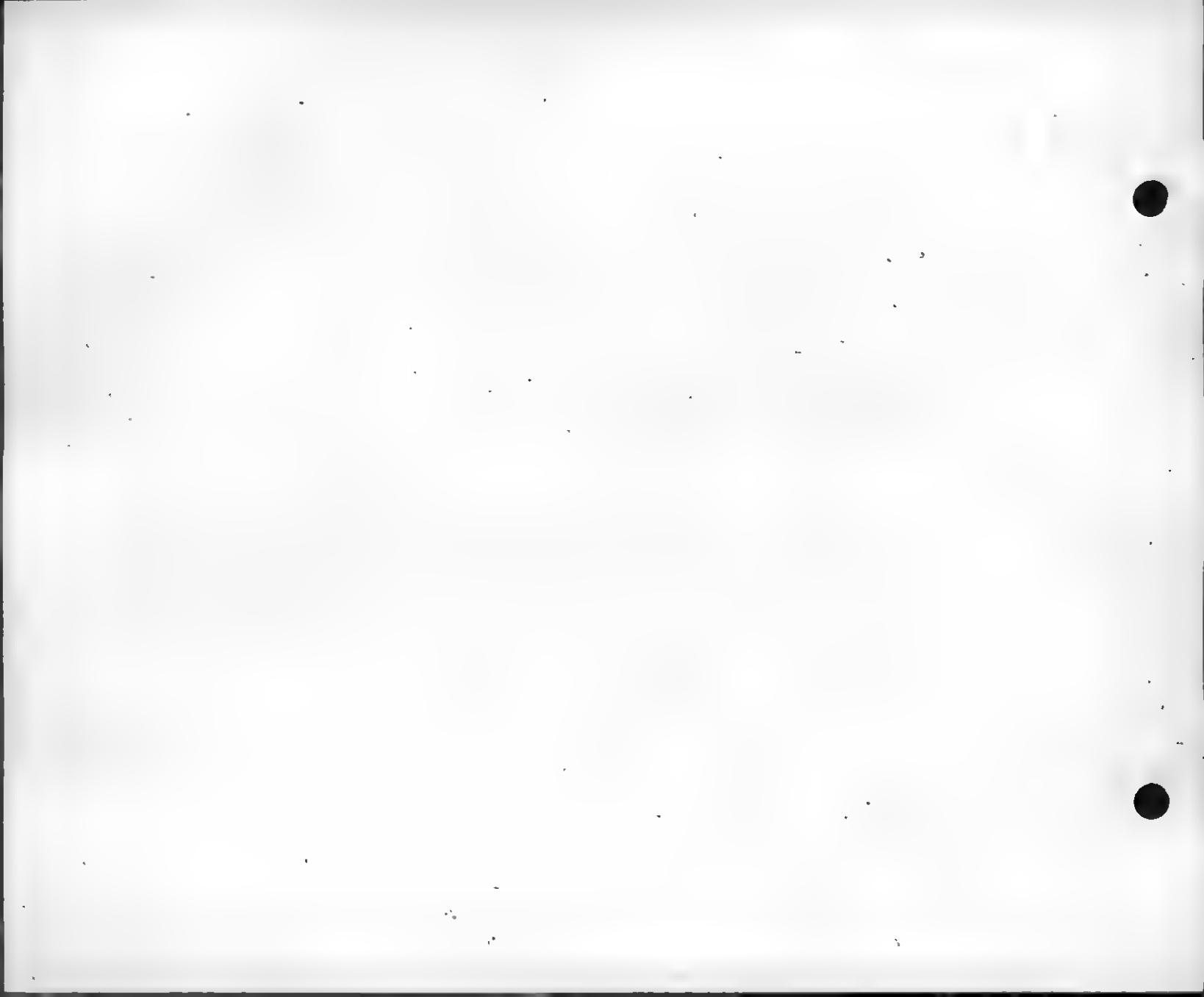
CERTIFICATE OF DEATH

DECEASED-NAME (Type or print) ERIS		First	Middle	Last	20. DATE OF DEATH Month March Day 23 Year 1968			2b HOUR 1:55 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 4/27/33		6. AGE (In years last birthday) 34 YRS		F UNDER 1 YEAR MONTHS DAYS HOURS M.N.	
7a. BIRTHPLACE (State or foreign country) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 14117 Rippling Brook dr	
14. FATHER'S NAME First Isaac Middle Rodgin Last Phoebe		15. MOTHER'S MAIDEN NAME First Phoebe Middle Rosenthal Last Rosenthal							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO 579-42-1892		17. INFORMANT Norman Stein		Address 14117 Rippling Brook Dr Silver Spring Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Tumor, right frontal lobe 2381 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 237X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan 25, 1968 , to Mar 23, 1968 , that (I) (was) last saw the deceased alive on Mar 23, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Walter E. Goetz				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/23/68	
22d. PHYSICIAN'S NAME (Type) WALTER E GOETZ - M.D.				22e. ADDRESS 2309 - SHOREFIELD RD. WHEATON - MD					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3/24/68		23c. NAME OF CEMETERY OR CREMATORY Greenwood		23d. LOCATION (City or Town) (County) (State) Greenbelt Md			
24. FUNERAL DIRECTOR Demond Dengerly's Sons				ADDRESS 2571 14th St NW		REC'D BY REGISTRAR MAR 26 1968		25. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Case cleared & medical examiner
Dr Ball 3/23/68 10:55 AM



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last MOSES C. STEWART			2a DATE OF DEATH Month Day Year 3 5 68			2b HOUR M	
3 SEX MALE		4 RACE NEGRO		5 DATE OF BIRTH JUNE 1, 1906		6 AGE (In years last birthday) YRS MONTHS DAYS 61	
7a BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.	
10 CITY OR TOWN OF DEATH GAITHERSBURG		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BOX 41 R.F.D. 1		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CEMENT FINISHER		12b. KIND OF BUSINESS OR INDUSTRY NONE	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY MONTG.		13c. CITY OR TOWN GAITH.		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e STREET AND NUMBER R.F.D. #1 BOX 41		14. FATHER'S NAME First Middle Last BENJAMIN STEWART		15. MOTHER'S MAIDEN NAME First Middle Last ANNIE WILSON			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NO		16b SOCIAL SECURITY NO.		17. INFORMANT Address MRS MARY STEWART BOX 41 R.F.D. 1 GAITH, MD			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> 185X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Prostate</u> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 11							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>1955</u> , 19 <u>55</u> to <u>3/15/68</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2/1/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <u>L. L. Leal M.D.</u> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						22c DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <u>L. L. Leal</u>		22e ADDRESS <u>Gaithersburg - Md</u>					
23a BURIAL, CREMAT., REMOVAL (Specify)		23b DATE <u>3-9-1968</u>		23c NAME OF CEMETERY OR CREMATORY <u>ST. ROSE</u>		23d LOCATION (City or Town) (County) (State) <u>Gaithersburg Mtg. Md.</u>	
24 FUNERAL DIRECTOR <u>Robert R. Szwedon - Rockville, Md</u>		ADDRESS		25a. REC'D BY REGISTRAR <u>Mar 14 1968</u>		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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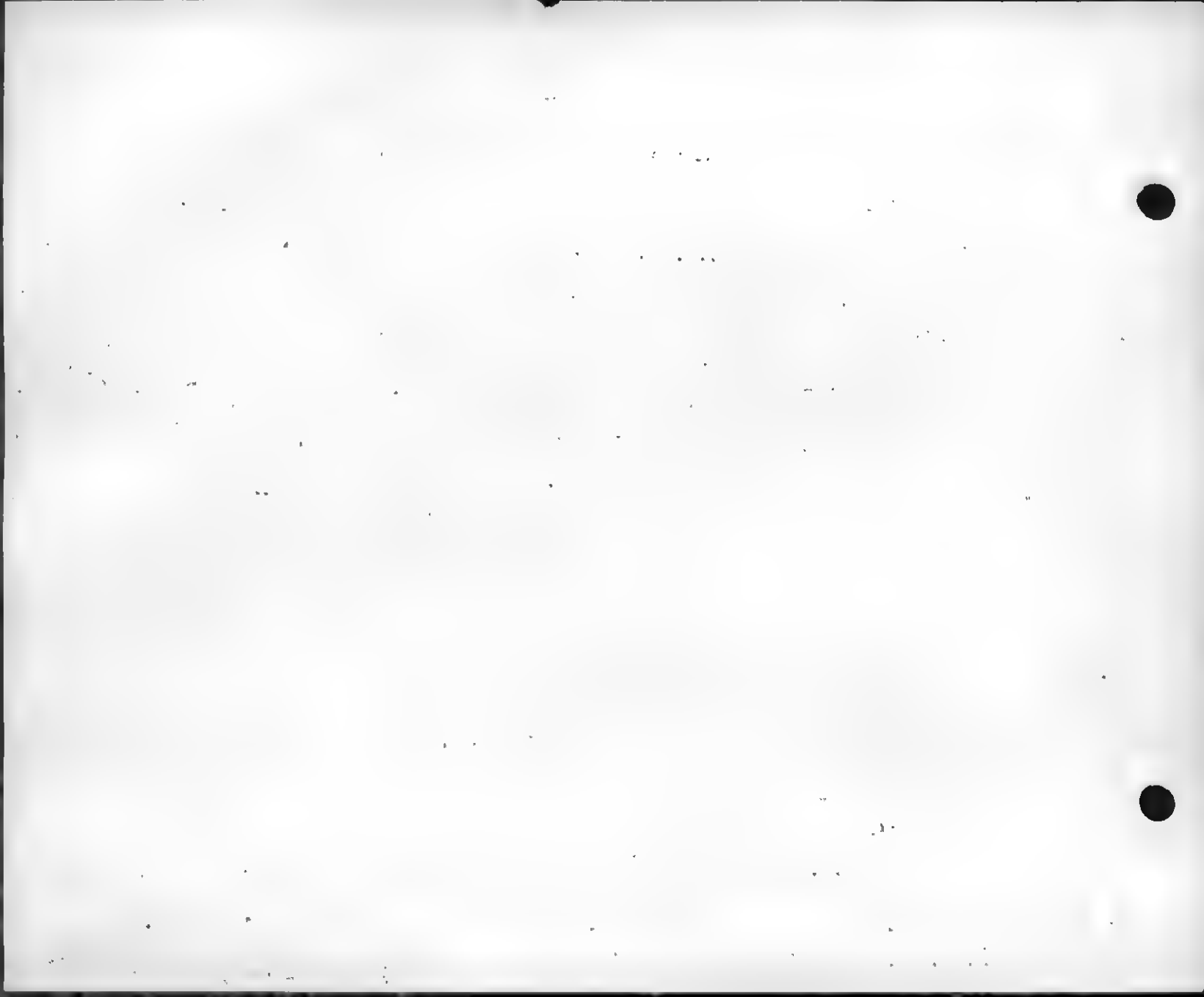
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 5 Film G399 4/4/68 kk

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) BENJAMIN RAYMOND STRONG Last		2a. DATE OF DEATH Mar Month 28 Day 68 Year		2b. HOUR 1830 P
3 SEX Male	4 RACE Caucasian	5 DATE OF BIRTH 2 Dec 1968 1920	6 AGE (In years lost birthday) 41 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9 COUNTY OF DEATH Montgomery County Md.	
10 CITY OR TOWN OF DEATH Bethesda	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) U.S. Naval Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Pilot USN	12b. KIND OF BUSINESS OR INDUSTRY Pilot	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE VA.	13b. COUNTY Alexandria	13c. CITY OR TOWN Alexandria	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 110 Luna St.
14 FATHER'S NAME First Middle Last ROY STRONG	15. MOTHER'S MAIDEN NAME First Middle Last MYRTLE TRAINHAM			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, no, or unknown) Yes 1938-1958	16b. SOCIAL SECURITY NO.	17. INFORMANT Address Mrs. Myrtle L. Byrd, 7436 Towers St., FallsCh., Virginia/		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Nutritional Cirrhosis , with Hepatic failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Necrotizing Pneumonitis with Abscess formation DUE TO, OR AS A CONSEQUENCE OF right upper lobe (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 26 November 1967 to 28 March 1968 , that (I) (we) last saw the deceased alive on 28 March 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Frank CDR MC USN MD DEGREE	ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 29 March 1968		
22d. PHYSICIAN'S NAME (Type) F.C. BLACKBURN LCDR MC USN	22e. ADDRESS Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 4-1-68	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery	23d. LOCATION (City or Town) (County) (State) Louisa County, Virginia	
24. FUNERAL DIRECTOR R. J. MURPHY, Arlington, Va.		25a. RECD BY REGISTRAR DATE APR 3 - 1968	25b. REGISTRAR'S SIGNATURE Francis Judge	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-101. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF ESTI- DEATH MATED			2b HOUR		
BERNARD DANIEL STURGIS						3 14 1968			Night		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c DATE PRONOUNCED DEAD			2d HOUR		
MALE	WHITE	4-5-43	24 YRS			Month 3 Day 14 Year 1968			6:00 PM		
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
MARYLAND		U.S.A.				MONTGOMERY			Md.		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
TAKOMA PARK			WASH. SAN. & HOSP.								
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?		
Md.			P.G.			HYATTS.			YES <input type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13a STREET AND NUMBER					
BERNARD STURGIS			LILLIAN			4205 OGLETHORPE ST.					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
YES			1962-1964			ROBERT JONES			6215 42ND AVE. HYATTS.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RENAL 9507 DUE TO, OR AS A CONSEQUENCE OF (b) (a) apyxia from aspiration of gastric contents DUE TO, OR AS A CONSEQUENCE OF (c) (b) Overdose of ruys. Larvon & Librium 1 1/2 hour										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 97.1											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR AM PM Night PM 3 14 1968			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) Took overdose of drugs -					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home Apartment.			21f. LOCATION Street or R.F.D. No City or Town County State 7519 Maple Ave Apt 4 Takoma Park Mont. Md.					
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)			22b DATE SIGNED March 14, 1968					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			March 18, 1968			Ft Lincoln Cemetery			Colmar Manor Pro Geo Md.		
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
F. Gasch's Sons			Hyattsville, Md.			DATE MAR 19 1968					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and in any event, within 72 hours after death should be filed with the State Dept. of Health prior to burial, cremation, or removal.

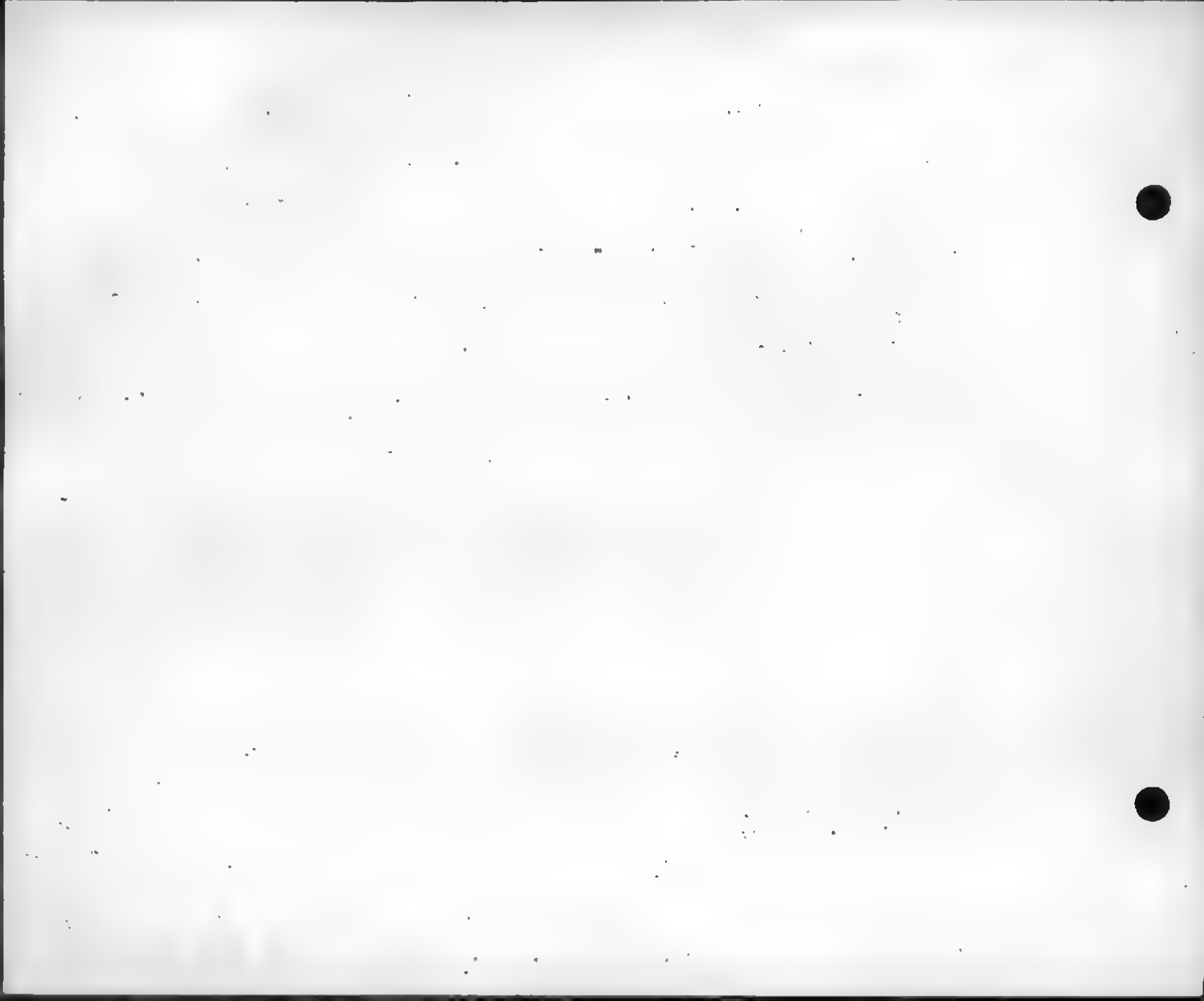
VR AT5 (4)
30M REV 1/68

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

344611

DECEASED NAME (Type or print) LAWRENCE			First	Middle	Last SULLIVAN	2a. DATE OF DEATH Month MARCH Day 7 Year 1968			2b. HOUR 10:30 PM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH Aug. 15, 1898		6. AGE (In years last birthday) 69 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) California		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6908 Oakridge Ave.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired-U.S. Govt.		12b. KIND OF BUSINESS OR INDUSTRY - -					
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6908 Oakridge Avenue	
14. FATHER'S NAME First Middle Last Jeremiah Sullivan				15. MOTHER'S MAIDEN NAME First Middle Last Ellen Damody							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) Yes 1916				16b. SOCIAL SECURITY NO 579-09-4326		17. INFORMANT Address Margaret T. Sullivan- See Item No. 13.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 420											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 1964 to 3/7, 1968 , that (I) (we) last saw the deceased alive on 3/6, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE W. Tabb Moore						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 3/7/68			
22d. PHYSICIAN'S NAME (Type) W. TABB MOORE						22e. ADDRESS 7203 Maple Ave Chevy Chase Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 3-12-1968		23c. NAME OF CEMETERY OR CREMATORY Creda Hill Crematory		23d. LOCATION (City or Town) (County) (State) Suitland, Md.					
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. NW Wash. D.C.						25a. RECD BY REGISTRAR MAR 13 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

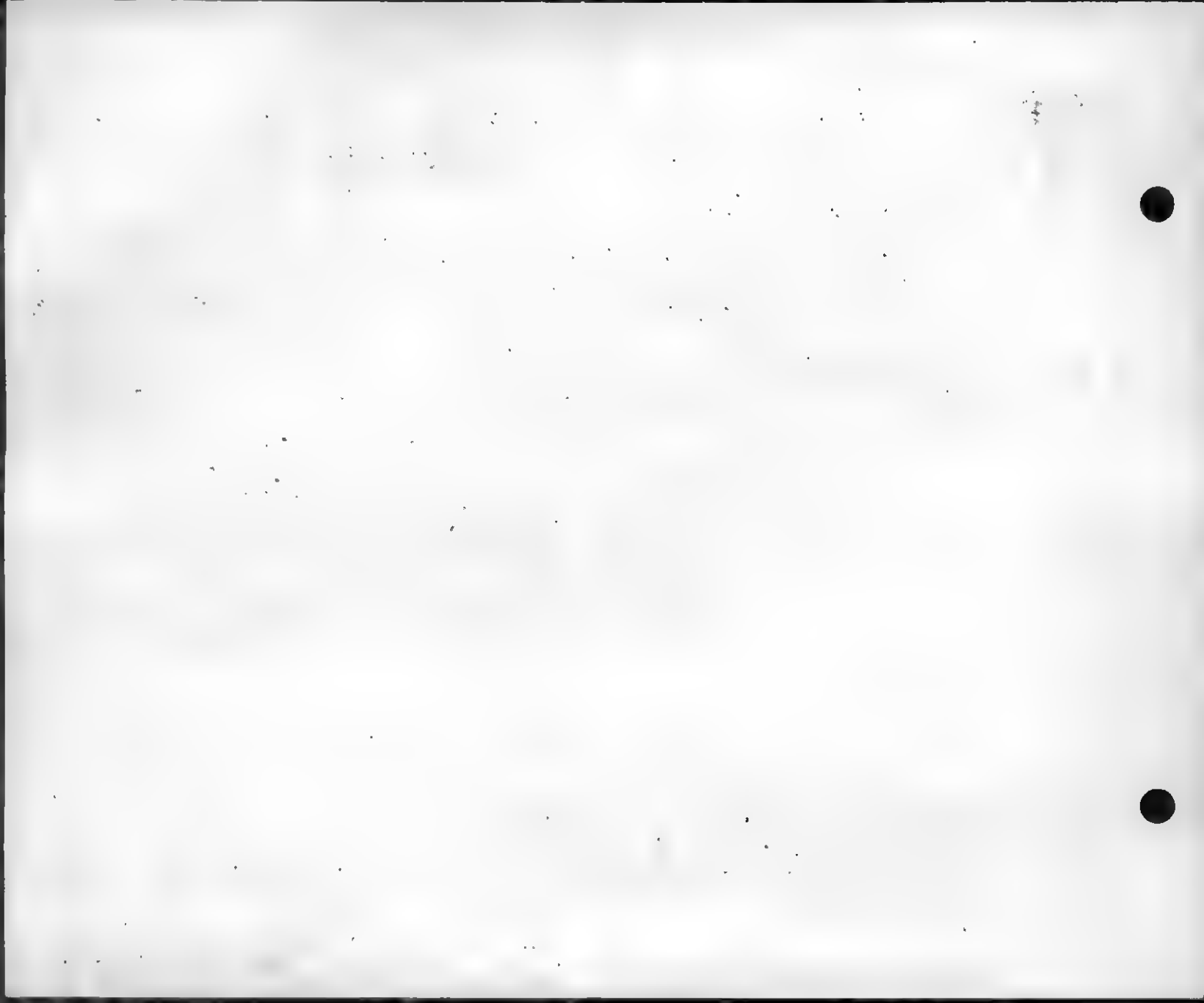


TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 3 and 4) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD 276
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last <i>Arthur Taylor Sutton</i>			2a. DATE OF DEATH Month Day Year <i>March 30 1968</i>			2b. HOUR <i>11:53 PM</i>	
3 SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>Sept. 13, 1883</i>		6 AGE (in years last birthday) <i>84</i> YRS.	
7b BIRTHPLACE (State or foreign country) <i>Oklahoma</i>		7c CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i> Md	
10 CITY OR TOWN OF DEATH <i>Winey</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Brook Grove Foundation</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Self Emp. Suppl.</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Teaching</i>	
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Maryland</i>		13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Silver Spring</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER <i>2007 Lansdowne Way</i>		14 FATHER'S NAME First Middle Last <i>Colonio Harris Sutton</i>		15 MOTHER'S MAIDEN NAME First Middle Last <i>LETA J. DAVIS</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, not or unknown <input type="checkbox"/> (If yes give war or dates of service) <i>NO</i>		16b SOCIAL SECURITY NO. <i>534-22-6127</i>		17 INFORMANT <i>CHARLES A. SUTTON</i>		Address <i>2007 Lansdowne Way S.E. MD.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>on the previous morning</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebro Vascular Accident</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>H.C.V.D.</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i> <i>2 hr</i> <i>hrs</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4"</i>							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>2/17/68</i> to <i>3/30/68</i> , that (I) (we) last saw the deceased alive on <i>3/2/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <i>A. H. LIGOW</i>		22c. DATE SIGNED <i>3/31/68</i>		22d. PHYSICIAN'S NAME (Type) <i>A. H. LIGOW</i>		22e ADDRESS <i>SANDY SPRING MD</i>	
23a BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b DATE <i>4 APRIL 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>WALLA WALLA WASHINGTON</i>		23d. LOCATION (City or Town) (County) (State) <i>WALLA WALLA WASHINGTON</i>	
24 FUNERAL DIRECTOR <i>RINARDI FUNERAL HOME</i>		ADDRESS <i>1401 GEORGIA AVE NW</i>		25a. REC'D BY REGISTRAR <i>APR 2 1968</i>		25b REGISTRAR'S SIGNATURE <i>Charles J. J...</i>	

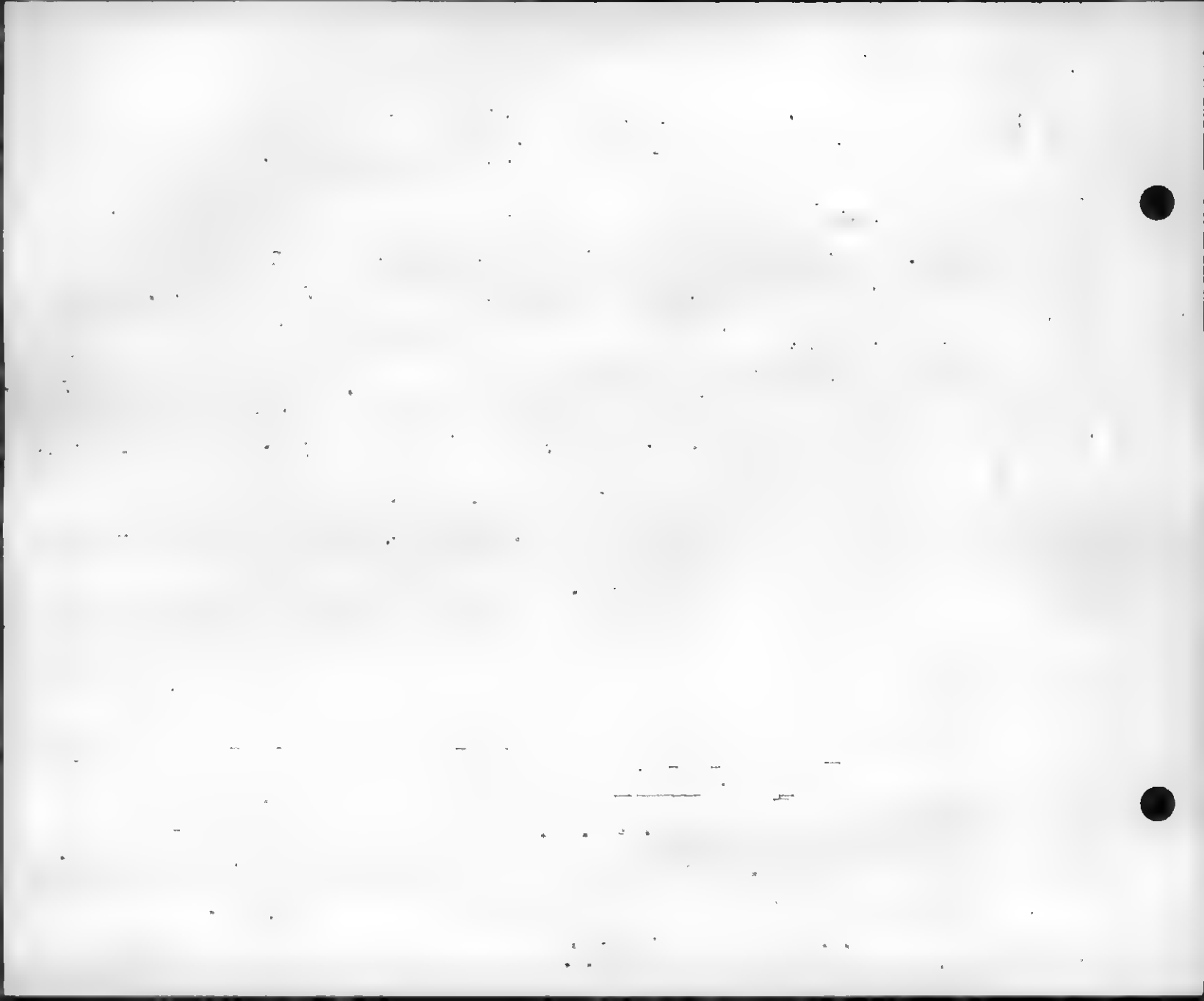


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD-473
MAY 1968
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Harriet Underwood Symonds			2a. DATE OF DEATH Month March Day 25 Year 1968			2b. HOUR 4:15 M	
3. SEX Female		4. RACE white		5. DATE OF BIRTH October 29, 1871		6. AGE (In years last birthday) 96 YRS.	
7a. BIRTHPLACE (State or foreign country) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Silver Springs		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Fairland Nursing Home		12a. USUA. OCCUPATION (Kind of work done during most of working life, except retired) School Teacher		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md		13b. COUNTY Montg		13c. CITY OR TOWN Takoma Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 7201 Cedar Ave.		14. FATHER'S NAME First Edward Middle Underwood Last Underwood		15. MOTHER'S MAIDEN NAME First Emma Middle Smith Last Smith			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT Mrs Martha Paull		Address 7201 Cedar Ave Takoma Park Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary edema							1-2 days
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure							1-2 days
DUE TO, OR AS A CONSEQUENCE OF (c) Bronchial pneumonia, acute							1-2 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cachexia and advanced age.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No. 15444 Columbia Pike City or Town Burtonsville County Montgomery State Md			
22a. I certify that (I) (this hospital) attended the deceased from 9-18-65 , 19 65 , to 3-25-68 , 19 68 , that (I) (we) last saw the deceased alive on 3-24-68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John R. Spencer M.D. DEGREE				22c. DATE SIGNED 3-25-68			
22d. PHYSICIAN'S (NAME) (Type) John R. Spencer				22e. ADDRESS 15444 Columbia Pike, Burtonsville Md.			
23a. BURIAL, CREMATION, REMOVAL Specify BURIAL		23b. DATE 3/26/68		23c. NAME OF CEMETERY OR CREMATORY George Washington Cem		23d. LOCATION (City or Town) (County) (State) Pn Geo Co Md.	
24. FUNERAL DIRECTOR W.R. Huntemann & Son ADDRESS Wash D.C.				25a. REC'D BY REGISTRAR DATE MAR 26 1968		25b. REGISTRAR'S SIGNATURE Charles Jones	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) Tracey Elizabeth Tatum			2a DATE KNOWN OF DEATH ESTIMATED March 17 1968			2b HOUR 3:31 AM		
3 SEX Fe.	4 RACE W.	5 DATE OF BIRTH Nov 1 1967	6 AGE (in years last birthday) 4 YRS 4 MONTHS 17 DAYS	7 UNDER YEAR 4	8 UNDER 24 HRS 17	2c DATE PRONOUNCED DEAD March 17 1968		
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery		
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) none		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b COUNTY Montgomery		13c CITY OR TOWN Silver Spring		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 11419 Columbia Pike
14 FATHER'S NAME First Middle Last John Robert Tatum			15 MOTHER'S MAIDEN NAME First Middle Last Gayle Marrit Beavers					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. none		17. INFORMANT John R. Tatum		ADDRESS see #13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SKULL Fracture 768X DUE TO, OR AS A CONSEQUENCE OF (b) due to trauma DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 hr.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b TIME OF INJURY Month, Day, Year 10 PM 3 17 1968		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) beat or shook child violently - striking head on hard object				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home		21f LOCATION Street or R.F.D. No Silver Spring		City or Town County State Mont. Md		
22a I certify that I took charge of the remains described above, held on death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE John G. Ball			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED 3/17/68		
EXAMINER'S NAME (Type) John G. Ball			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
			ADDRESS (Street, city, town, or county) Rockville, Maryland					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 3/19/68		23c NAME OF CEMETERY OR CREMATORY Parklawn		23d LOCATION (City or Town) (County) (State) Rockville, Maryland		
24 FUNERAL DIRECTOR Joseph Gawler's Sons				ADDRESS 5130 Wisconsin Av., Wash. D.C.		25a REC'D BY REGISTRAR MAR 21 1968		25b REGISTRAR'S SIGNATURE Charles Judge



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the original of this certificate. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		Month	Day	Year	2b HOUR		
Ennis		Walter		TAYLOR				DEATH MATED		3-30		1968	8:00 P.M.		
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (in years last birthday)		7 UNDER 1 YEAR		8 UNDER 24 HRS		2c DATE PRONOUNCED DEAD		Month	Day	Year	2d HOUR
Male	Cauc.	Sept. 6, 1908		59 YRS.		MONTHS DAYS HOURS MIN				Mar 30 1968		8:00 P.M.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH									
Texas		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery						Md			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b KIND OF BUSINESS OR INDUSTRY									
Bethesda		Bethesda Naval		Naval Officer		USN									
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER							
Maryland		Montgomery		Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9509 Edgely Road							
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First		Middle		Last	
June		Taylor		Loxa		Bales									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS		9509 Edgely Rd.				Beth. Md.			
yes		1932-1961		459-64-8342		Mrs. Geraldine A. Taylor									
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))		PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)			
4109		Acute Myocardial Infarction		Coronary Artery		Coronary Artery Heart Disease									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		4201													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f LOCATION Street or R.F.D. No		City or Town		County		State					
22a I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from		Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Belden R. Reap		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED			
EXAMINER'S NAME (Type)		Belden R. Reap, M. D.				ADDRESS (Type, city, town, or county)		Wheaton				3/30/1968			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)					
Burial		4-3-68		Arlington National		Arlington, Va.									
24 FUNERAL DIRECTOR		Robert A. Pumphrey Funeral Home		ADDRESS		25a RECD BY REGISTRAR		25b REGISTRAR'S SIGNATURE							
7557 Wisconsin Ave., Bethesda, Md.						APR 8 - 1968		[Signature]							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

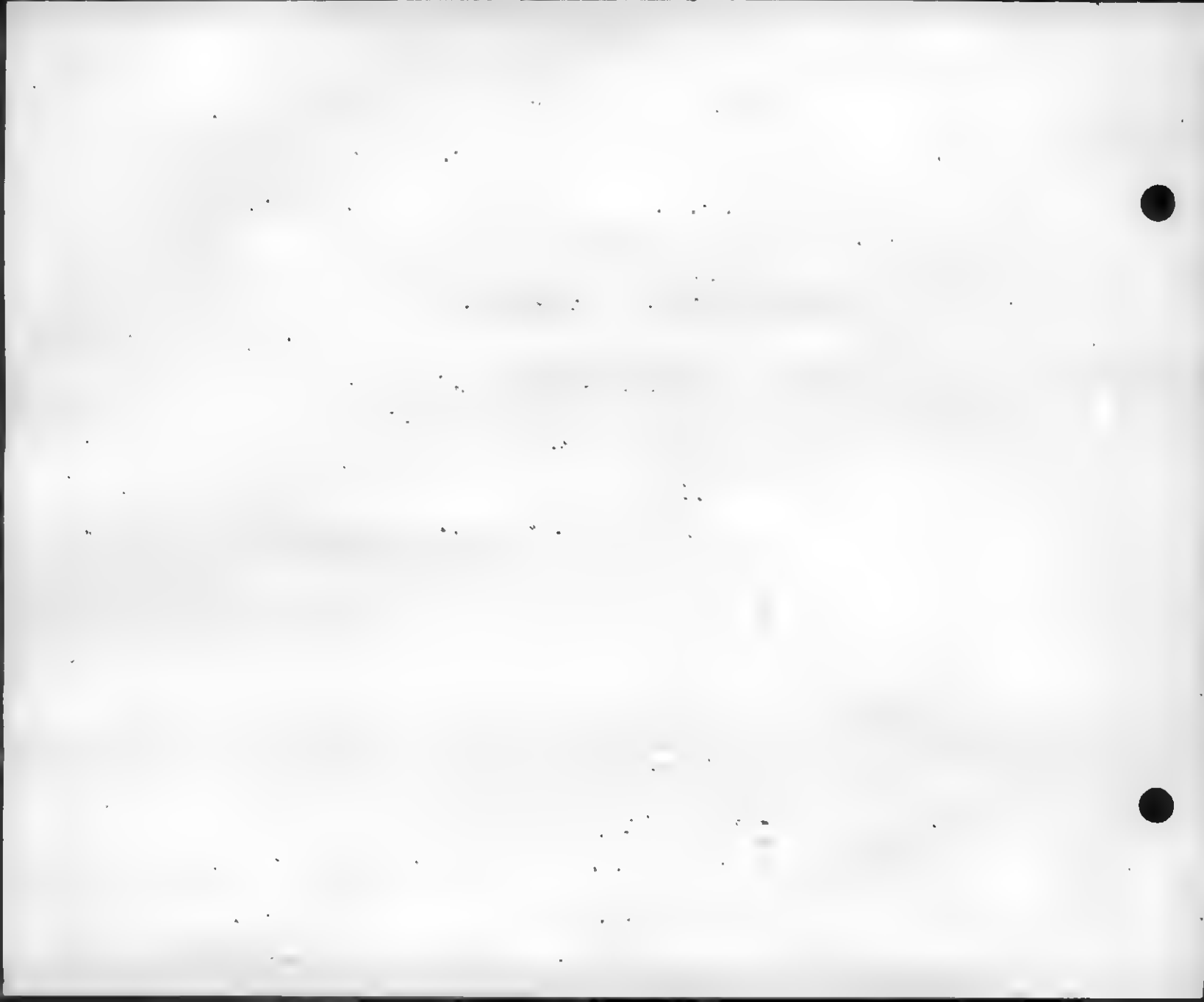
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Mary Virginia			First Middle Last Tice			2a. DATE OF DEATH Month March Day 22 Year 1968			2b. HOUR 5:45 AM		
3. SEX Female			4. RACE White			5. DATE OF BIRTH Jan. 4, 1874			6. AGE (In years last birthday) 94 YRS.		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH CATHERSBURG-Courtsburg			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Asbury Methodist Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution, as above, before admission) STATE Maryland			13b. COUNTY Howard			13c. CITY OR TOWN CELESTINE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER RUSSIA			14. FATHER'S NAME First Adam Middle Shearer Last Shearer			15. MOTHER'S MAIDEN NAME First Mary Middle Elizabeth Last Albau gh					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no			16b. SOCIAL SECURITY NO 212-20-7081			17. INFORMANT Methodist Home Record			Address		
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Generalized arteriosclerosis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MIN. 2 YRS. 10 YRS.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 4/1/63 , 19 63 , to 3/22/68 , 19 68 , that (I) (we) last saw the deceased alive on 3/19/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Henry C. Scruggs, M.D.						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 3/22/68		
22d. PHYSICIAN'S NAME (Type) Henry C. Scruggs, M.D.						22e. ADDRESS 5413 Cedarlane Bethesda Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 3-25-68			23c. NAME OF CEMETERY OR CREMATORY Good Shepherd			23d. LOCATION (City or Town) (County) (State) Ellicott City Howard Md		
24. FUNERAL DIRECTOR Hymenabram Slack						ADDRESS Ellicott City, Md.			25a. FILED BY REGISTRAR DATE MAR 28 1968		
									25b. REGISTRAR'S SIGNATURE Charles Judge		

MEDICAL CERTIFICATION



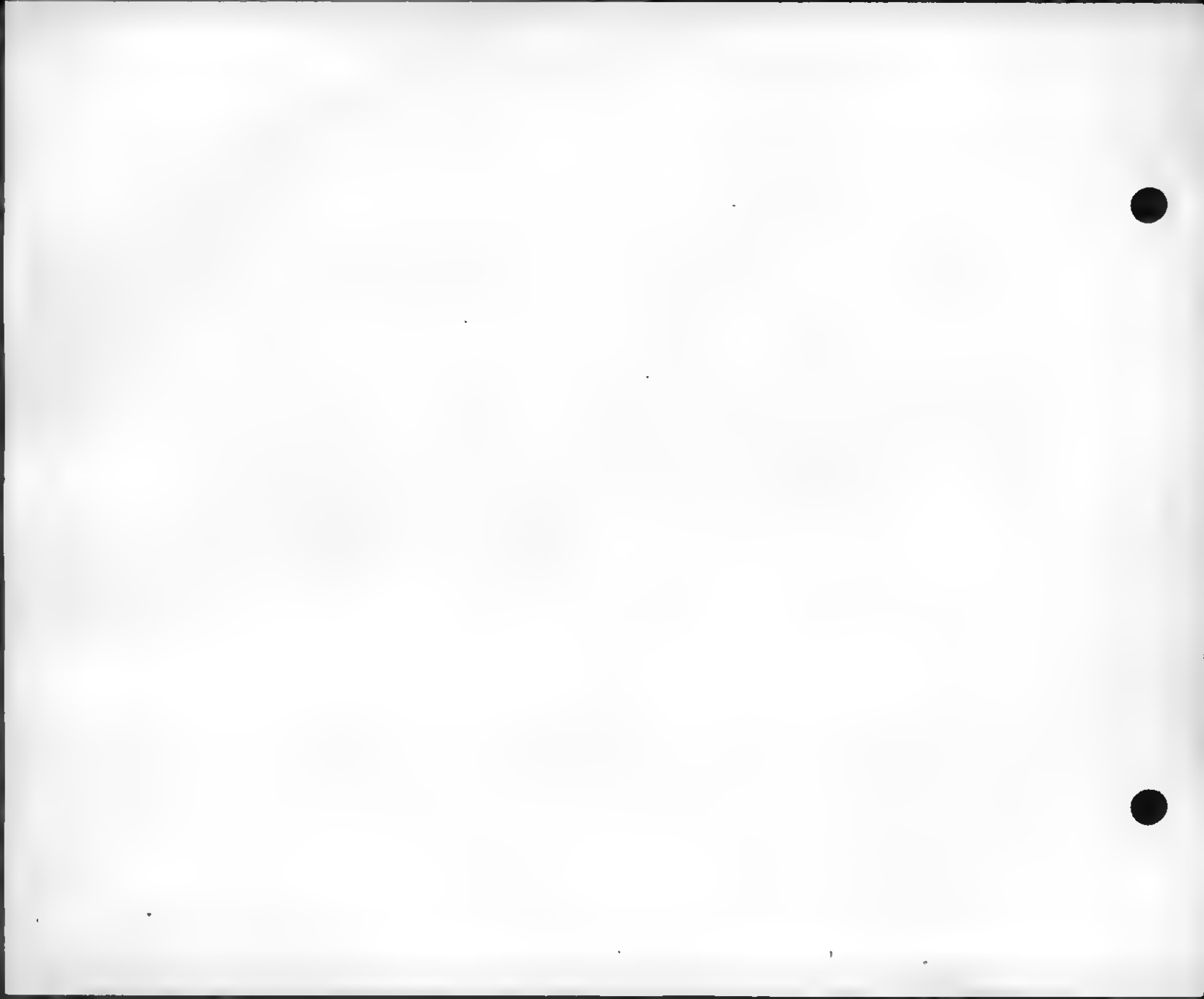
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 2 Film G3-9 3/27/68 kx
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE		c. LENGTH OF STAY IN ID 5 mos. 14 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BETHESDA-SILVER SPRING NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First NETTIE Middle M Last TOLSON		4 DATE OF DEATH Month MARCH Day 14 Year 1968	
5. SEX FE	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-8-79
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY VETERAN'S ADM.	9. AGE (in years last birthday) 88
11. BIRTHPLACE (County & State, or foreign country) LANDOVER, MD.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME ARTHUR W. TOLSON		14. MOTHER'S MAIDEN NAME ELLA SUIT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 578-62-9288-51	
17. INFORMANT H. S. CHART		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure X DUE TO (b) Pulmonary Embolism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 10 hr. 24 hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Advanced Arteriosclerosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/12 , 19 67 to 3/14 , 19 68 , that (I) (we) last saw the deceased alive on 3/14 19 68 , and that death occurred at 8:50 P.M. from causes and on the date stated above.			
22a. SIGNATURE Frank J. Jagers Jr.		22b. DATE SIGNED 3/14/68	
22c. PHYSICIAN'S NAME (Type) FRANK J. JAGGERS JR.		22d. ADDRESS 5707 WISCONSIN AVE Chevy Chase	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Cremation	3/15/68	Cedar Hill	Suitland Md.
24. FUNERAL DIRECTOR Jos. Gawler's Sons Inc		25a. REC'D BY REGISTRAR MAR 21 1968	
ADDRESS 5130 Wisconsin Ave NW Washington, DC		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1043. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

18-22 film 398
-20-63 mt
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4461

1 DECEASED NAME (Type or Print) APOLLON			First Middle Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTI <input type="checkbox"/> MATED <input type="checkbox"/> 3-1-1968			2b. HOUR 11:25 A.M.			
3 SEX Male	4 RACE White	5 DATE OF BIRTH 2-27-13	6 AGE (in years last birthday) 55 YRS.	7 UNDER MONTHS	8 YEAR	9 UNDER 24 HRS. HOURS	10 MIN	2c. DATE PRONOUNCED DEAD 3-1-1968			2d. HOUR 11:25 A.M.	
7a. BIRTHPLACE (State or foreign country) Ukraine		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH MONTGOMERY			Md			
10 CITY OR TOWN OF DEATH Takoma Park		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Language Researcher			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (where deceased lived, if institution, Residence before admission) STATE Virginia		13b. COUNTY Fairfax		13c. CITY OR TOWN Vienna		13d. INSIDE CITY LIMITS <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 2540 Chain Bridge Road				
14 FATHER'S NAME Pawlo Trembowezky			First Middle Last			15. MOTHER'S MAIDEN NAME Lydia Kozlovsky			First Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 211-26-4117		17 INFORMANT Hospital Records			ADDRESS 7600 Carroll Ave.				
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Massive Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF Associated with Hypertensive (b) Cardio Vascular Disease (c) Cardio Vascular Disease												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 331x												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year 19 P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Belden R. Reap			EXAMINER'S NAME (Type) BELDEN R. REAP			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED March 1, 1968
23a. BURIAL CREMATION, REMOVAL (Specify) Burial			23b. DATE March 5, 1968		23c. NAME OF CEMETERY OR CREMATORY Fairfield Union Cemetery			23d. LOCATION (City or Town) Fairfield, Adams Co. Pa.			(County) (State)	
24 FUNERAL DIRECTOR Clarence E. Wilson			ADDRESS Emmitsburg, Md.			25a. REC'D BY REGISTRAR MAR 5 1968			25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

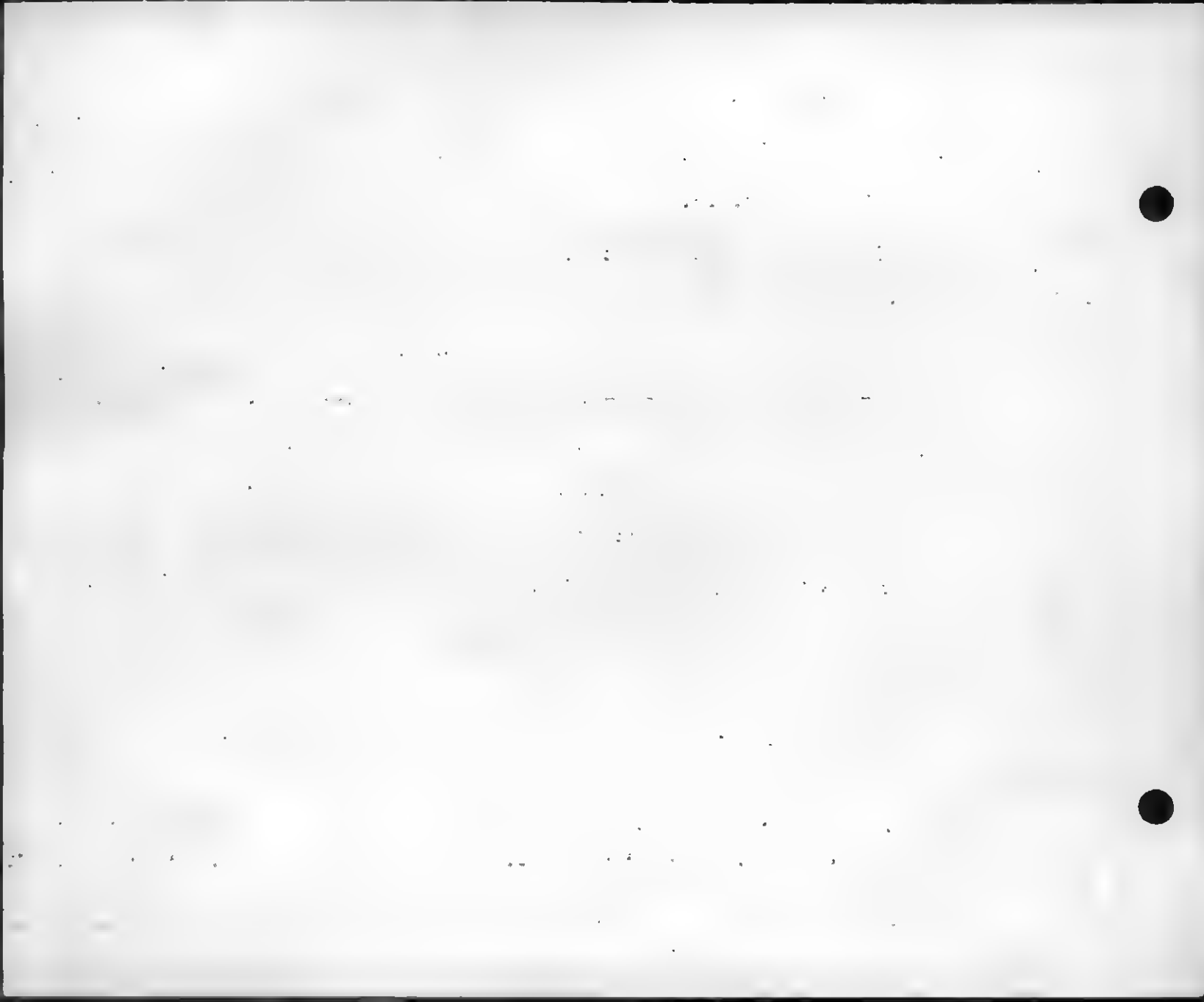
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 12-68

MD 273

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last Elizabeth Tripp		2a DATE OF DEATH Month Day Year March 8 1968		2b HOUR 1:40A
3 SEX Female	4 RACE White	5 DATE OF BIRTH 3/2/80	6 AGE (n years last birthday) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS 0 8
7a BIRTHPLACE (State or foreign country) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 716 Brent Road	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Music Teacher	12b. KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE Maryland	13b. COUNTY Montgomery	13c CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 716 Brent Road
14 FATHER'S NAME First Middle Last John Tripp	15. MOTHER'S MA DEN NAME First Middle Last Elizabeth Peters	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service) no --		
16b SOCIAL SECURITY NO 216-32-9111	17. INFORMANT Address Herman Hartman--125 S. VanBuren St. Rockville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART 1. DEATH WAS CAUSED BY: 431.0 IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Essential Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Atherosclerosis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 DAYS 30 YRS 30 YRS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CHRONIC RENAL FAILURE - Congestive Heart Failure				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED.	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)	21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from February 16, 1968, to March 9, 1968, that (I) (we) last saw the deceased alive on March 8, 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Gordon S. Rosenberger, M.D.	22c. DATE SIGNED March 8, 1968	22d. PHYSICIAN'S NAME (Type) Gordon S. Rosenberger, M.D.		
22e. ADDRESS 510 W. Montgomery Ave., Rockville, Md.				
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/11/68	23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Ullrich Funeral Home 4210 Belair Road.	25a. REC'D BY REGISTRAR DATE MAR 11 1968	25b. REGISTRAR'S SIGNATURE Charles J. [Signature]		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) JAMES PARKER TURNER SR.			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> EST. <input type="checkbox"/> 3 11 1968			2b. HOUR 4:47P			
3 SEX Male	4. RACE White	5. DATE OF BIRTH 5/7/1917	6 AGE (In years, last birthday) 50 RS	IF UNDER 1 YEAR MONTHS 5 DAYS 15	IF UNDER 24 HRS HOURS 4 MIN 47	2c. DATE PRONOUNCED DEAD Month March Day 11 Year 1968			
7a. BIRTHPLACE (State or foreign country) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Maint. Superintendent		12b. KIND OF BUSINESS OR INDUSTRY Bldg. Contractor		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spr.		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
14. FATHER'S NAME First Frank Middle Lavin Last Turner			15. MOTHER'S MAIDEN NAME First Helen Middle Mae Last Cronise			13e. STREET AND NUMBER 9803 Dallas Ave.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Army, yes			16b. SOCIAL SECURITY NO. W.W. II		17. INFORMANT Brother, Leslie L. Turner			ADDRESS 12212 Dalewood Dr. Wheaton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning 7000 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 97									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year 4 P.M. 3 11 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) in car motor in closed garage				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office bldg, etc.) Home		21f. LOCATION Street or R.F.D. No. 9803 Dallas Ave. City or Town Silver Spring County Montgomery State Md.					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE John W. Bell			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED - March 12, 1968			
EXAMINER'S NAME (Type) John W. Bell			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
			ADDRESS (Street, city, town, or county) _____						
23. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE March 15, 1968		23c. NAME OF CEMETERY OR CREMATORY Rock Creek			23d. LOCATION (City or Town) Washington D.C. (County) _____ (State) _____		
24. FUNERAL DIRECTOR Arthur Walters		ADDRESS 254 Carroll St.		DATE MAR 14 1968			25. REGISTRAR'S SIGNATURE [Signature]		

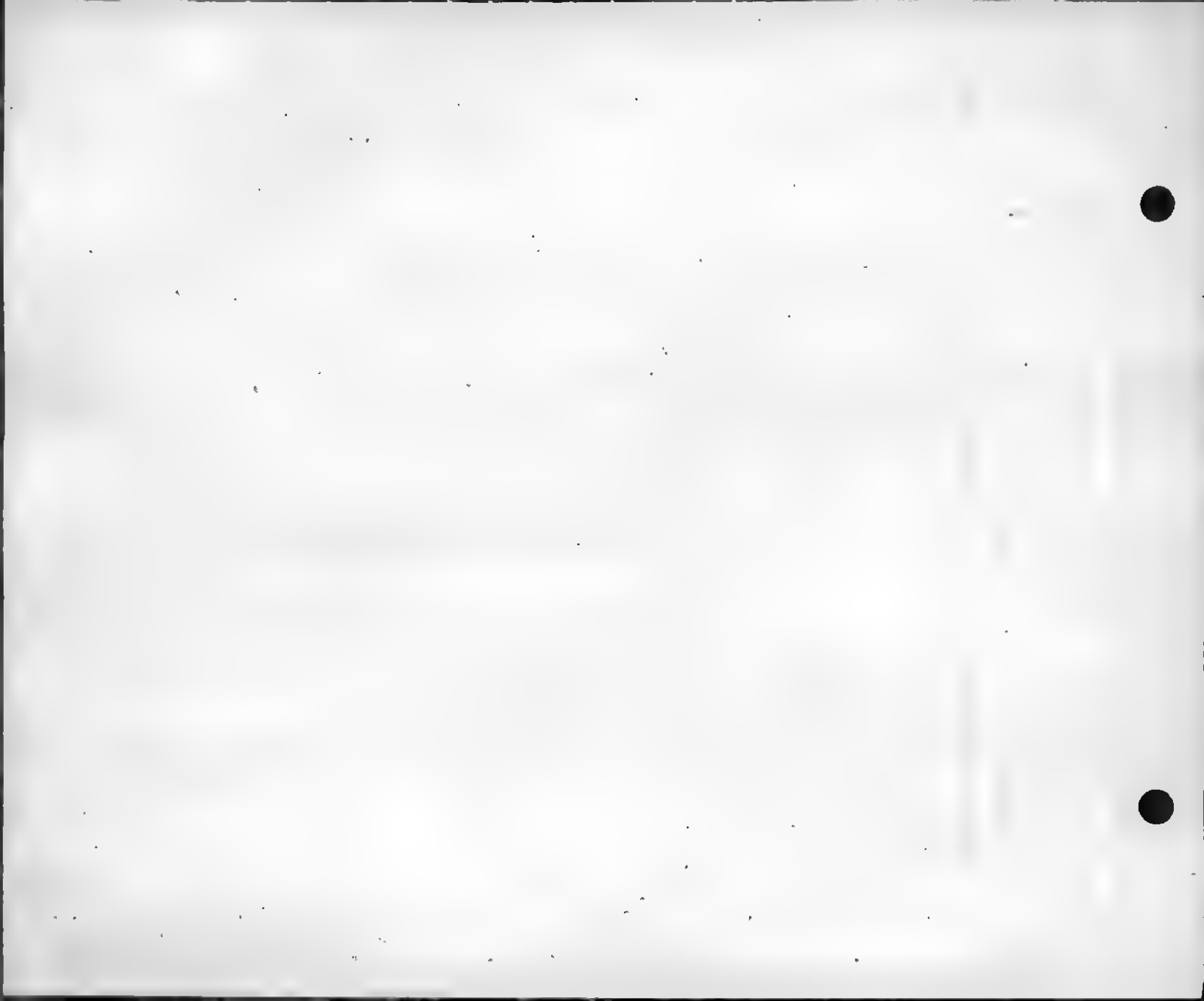


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Med to Notified and Appointed - 3/28/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH			2b. HOJR
NANNIE LEAH		TURNER		MARCH 28		1968			9:35 P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
7.	W.	3-11-1888		83 YRS		MONTHS		DAYS		HOURS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
W. VA		USA		Montgomery						Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Kensington		KENSINGTON GARDENS NURS. HOME		HOUSEWIFE		Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Md.		PRINCE GEORGE		RAINIER		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3735 Melba Ave			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO		17. INFORMANT		Address	
Franklin H.		ROBEY		Susan Martin		No		378-09-6911		Mark W. Turner Rockville, Md.	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Brain Tumor											Months
2381 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
232											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from January 1968, to March 28, 1968, that (I) (we) last saw the deceased alive on 3-19-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
Stuart L. Nelson		3-28-68		Stuart L. Nelson		831 University Blvd East Silver Spring					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		April 1, 1968		Ft Lincoln Cemetery		Colmar Manor Pro Geo				Md.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
F. Gasch's Sons		Hyattsville, Md.		DATE APR 1 - 1968		James J. Jones					

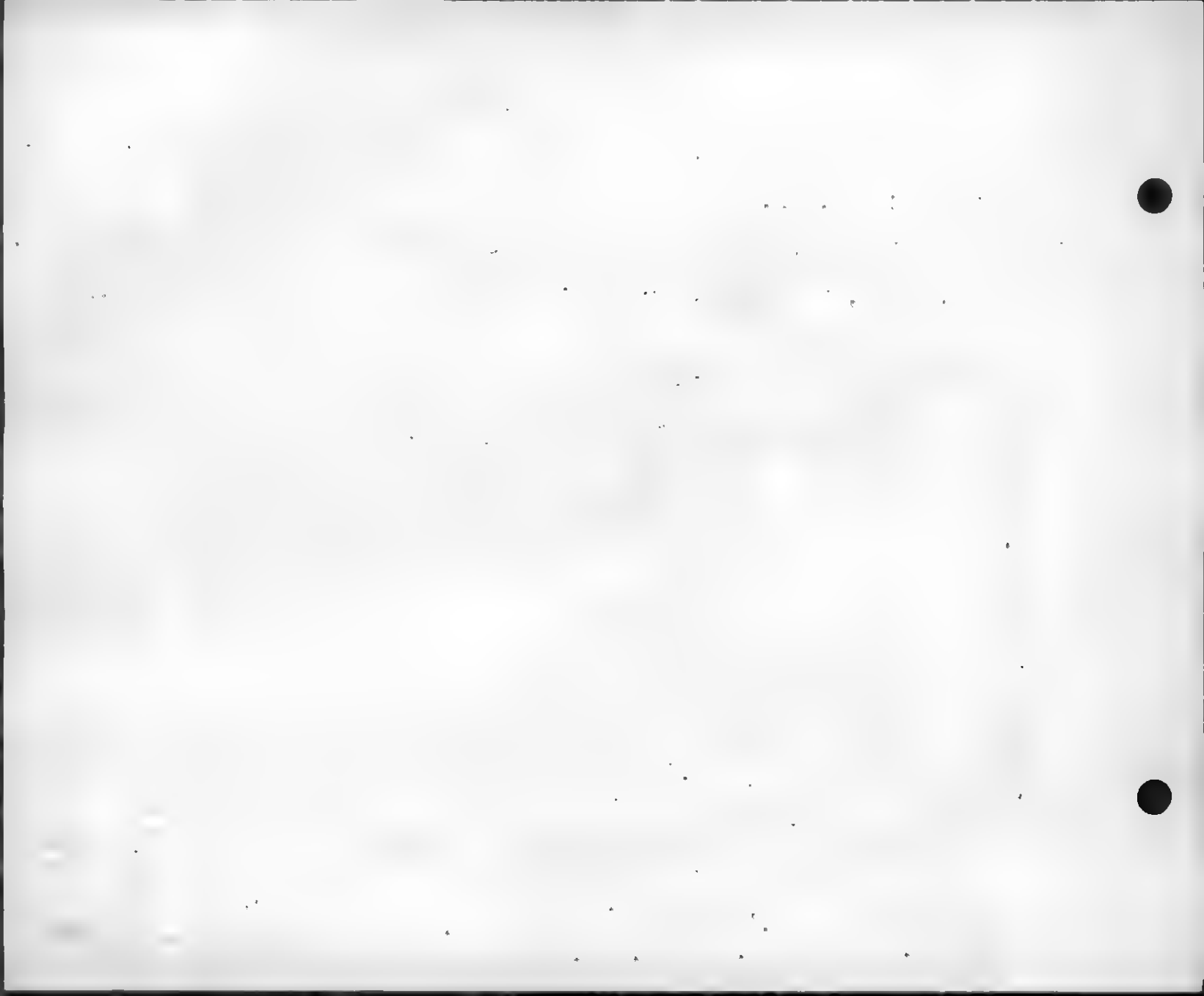


FOR STATE HEALTH DEPT.

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
JAMES LEE VANCE						Month Day Year			3 25 1968 6A		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	F UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD			2d HOUR
Male	White	3/11/18	50 YRS					Month Day Year			6A
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Goose Creek, Tex. USA									Montgomery Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Rockville Md.			5118 Russett Rd. Rock. Md.			Indust. Engineer			Eng. US Gvt.		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Rockville, Md.			Montgomery			Rockville			5118 Russett Rd. ROCK.		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		
George Vance			Josephine Sheppard			yes			467-05-2794		
17 INFORMANT			ADDRESS			18 CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
wife Barbara H.			5118 Russett Rd.			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Coronary Artery Heart Disease CONDITIONS, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
4201											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town County State		
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
22b DATE SIGNED			22c NAME OF CEMETERY OR CREMATORY			22d LOCATION (City or Town) (County) (State)					
3/25/1968			Ft. Rosecrans			San Diego, California					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			Mar 29, 1968			Ft. Rosecrans			San Diego, California		
24 FUNERAL HOME			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE					
C. Glen Carter			Silver Spg.			Judge					
Warner E. Pumphrey, Inc. 8434 Ga. Ave. Maryland											
DATE MAR 29 1968											



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

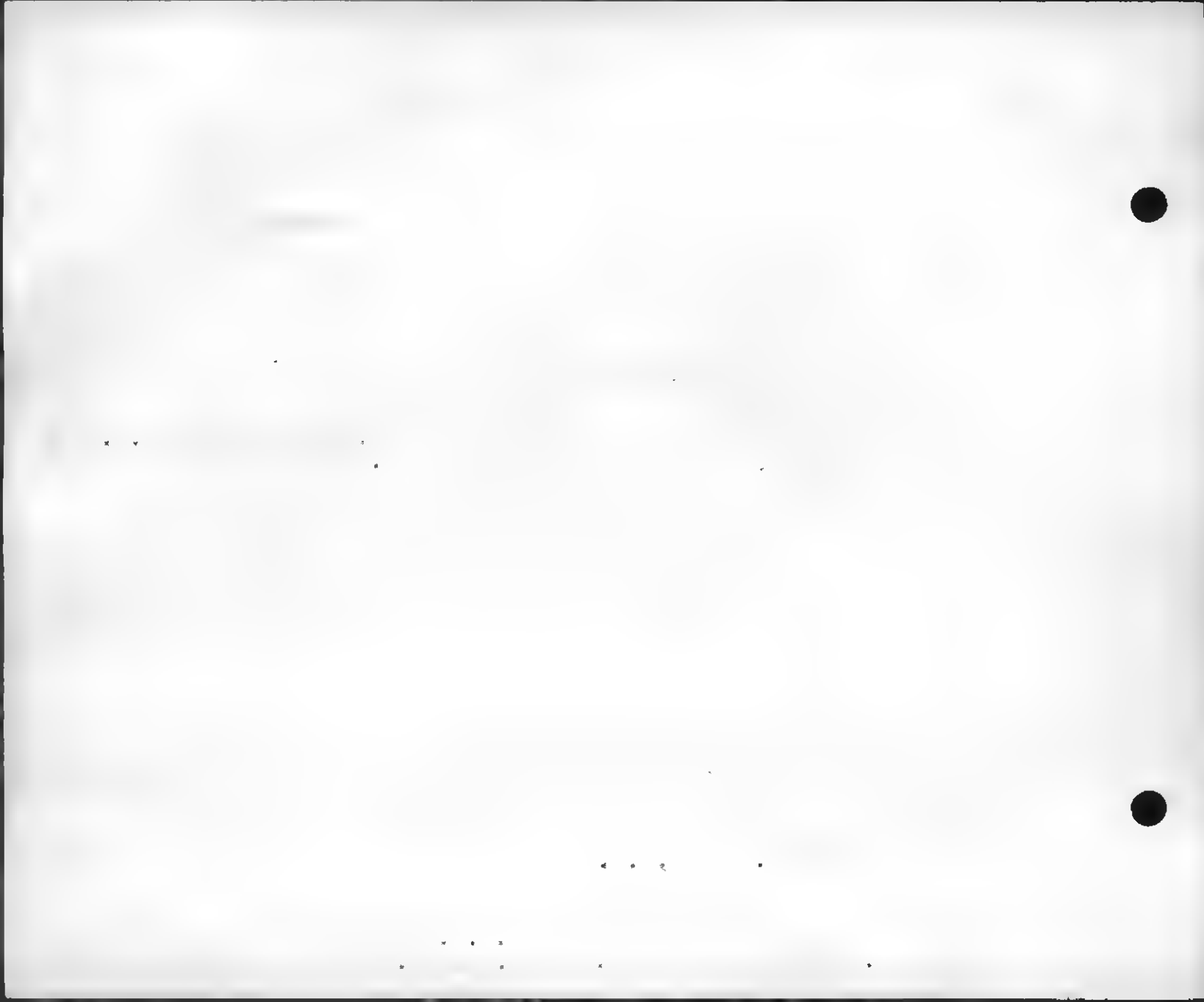
CERTIFICATE OF DEATH

04483

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

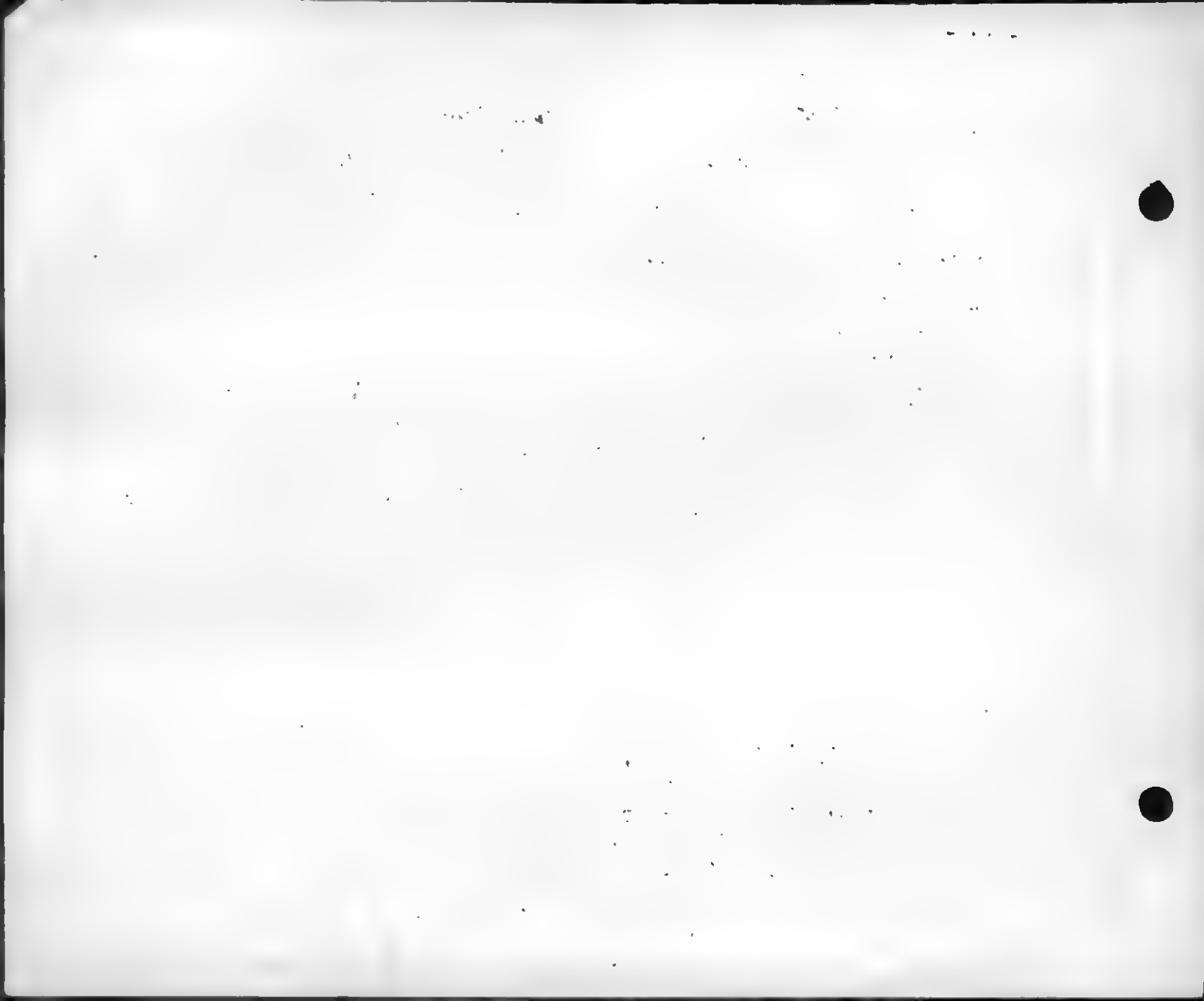
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley Chase</u> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3202 Turner Lane Ch. Ch. MD.</u> d. STREET ADDRESS <u>Chesley Chase, Maryland</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Madison</u> Middle <u>H.</u> Last <u>Varn</u>		4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>1968</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 11, 1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. EMPLOYEE - STANDARD ELECTRIC DIV.</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) <u>78</u> yrs
11. BIRTHPLACE (County & State, or foreign country) <u>SOUTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>	
13. FATHER'S NAME <u>JOHN J. VARN</u>		14. MOTHER'S MAIDEN NAME <u>HARRIET BISHOP</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES WWII</u>		16. SOCIAL SECURITY NO <u>577-46-1378A</u>	
17. INFORMANT (BRO. IN LAW) <u>MR. HARRY E. MERCIER</u>		Address <u>WASH. D.C. 20015</u> <u>3035 BEECH STREET</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO <u>Chronic obstructive Pulm Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>Pulm Emphysema & Chr. Bronchitis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>years</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>December 19 1965</u> to <u>3/16</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3/16</u> 19 <u>68</u> , and that death occurred at <u>2:20</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John J. Lynch</u>		22b. DATE SIGNED <u>3/16/68</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN J. LYNCH, M.D.</u>		22d. ADDRESS <u>1234 - 19th St NW WASH DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>MAR. 20/68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>ROCKVILLE, MONT. MD.</u>
24. FUNERAL DIRECTOR <u>MARTIN W. HAYSONG COMPANY</u>		25a. REC'D BY REGISTRAR <u>WASH. D.C.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. DATE <u>MAR 19 1968</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and competently filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) <i>VEZINA, Marie</i>			First Middle Last <i>MARIE - VEZINA</i>			2a. DATE OF DEATH <i>3/14/68</i>			2b. HOUR <i>12:30 P.M.</i>		
3 SEX <i>Female</i>			4. RACE <i>White</i>			5. DATE OF BIRTH <i>November 10 1877</i>			6. AGE (In years last birthday) <i>90</i> YRS.		
7a. BIRTHPLACE (State or foreign country) <i>Germany</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i> Md.		
10. CITY OR TOWN OF DEATH <i>Kensington Md.</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Kensington Gardens Sanatorium</i>			12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>WASH D.C.</i>			13b. COUNTY <i>D.C.</i>			13c. CITY OR TOWN <i>D.C.</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <i>636 Girard St N.E.</i>			14. FATHER'S NAME First Middle Last <i>Christian Kreuzer</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>unknown</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>			16b. SOCIAL SECURITY NO. <i>577-24-8898</i>			17. INFORMANT <i>Jean S. Kreuzer</i>			Address <i>Beltsville, Md. 5104 Dressing</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>arteriosclerotic heart disease</i>										<i>2 yrs</i>	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b) <i>generalized arteriosclerosis</i>										<i>10 yrs</i>	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>420C</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home farm street factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from <i>2/5/67</i> , to <i>3/14/68</i> , that (I) (we) last saw the deceased alive on <i>3/14/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE <i>[Signature]</i>			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>3/14/68</i>					
22d. PHYSICIAN'S NAME (Type) <i>B. F. Kreuzburg</i>			22e. ADDRESS <i>7852 16th NW Wash DC</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <i>3-16-68</i>			23c. NAME OF CEMETERY, OR CREMATORY <i>FT LINCOLN CEM</i>			23d. LOCATION (City or Town) (County) (State) <i>BLADENSBURG MD</i>		
24. FUNERAL DIRECTOR <i>W.W. Chamber</i>			14. ADDRESS <i>WASH. D.C.</i>			25a. REC'D BY REGISTRAR <i>Charles Jones</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>		



FOR STATE
HEALTH DEPT.

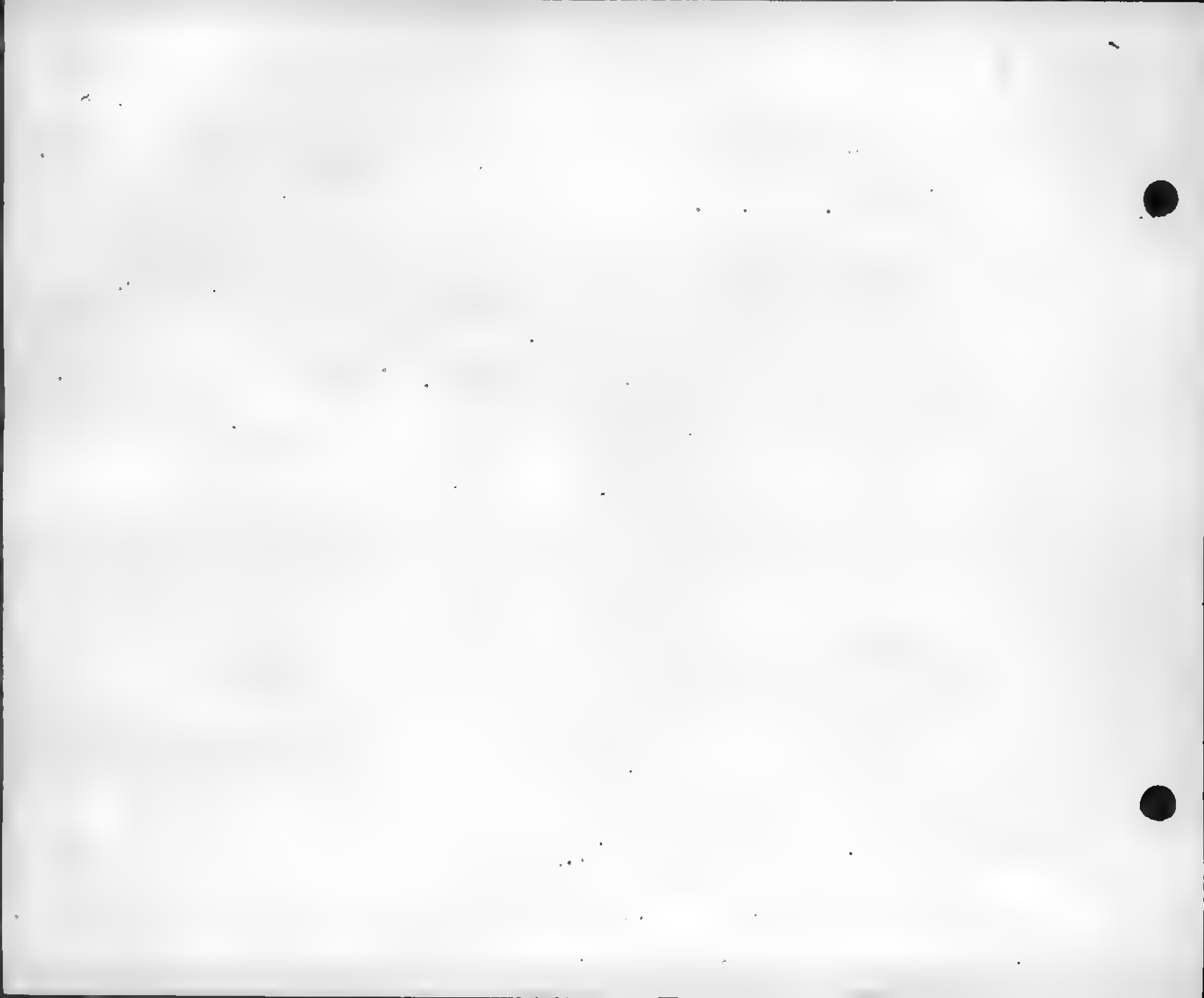
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> March 23, 1968			2b HOUR M		
Nathan			Walter			Walker					
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years at birthday)	F UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year			2d HOUR
M	W	10/26/11	56 YRS					March 23 1968			3P M
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Germantown Md.			U.S.A.						Montgomery Md		
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Silver Spring			Holy Cross Hosp.			Mechanic					
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Maryland			Montgomery			Takoma Park			13e STREET AND NUMBER 7006 Sycamore Ave.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Nathan			Walter Walker Sr.			Unknown					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17. INFORMANT			ADDRESS		
no			225-05-1841			Eva M. Walker			Same as Item 13.		
						daughter Wife					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (e) <u>4 IUI</u>											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
2d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f LOCATION Street or RFD No			City or Town		
									County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED		
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, City or Town, or County)			3/23/1968		
Belden R. Reap			M.D.								
Belden R. Reap			M.D.								
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			3-26-68			Ft. Lincoln Cemetery			Prince George County, Md.		
24 FUNERAL DIRECTOR			ADDRESS			25a DEATH BY CERTIFICATE			25b REGISTRAR'S SIGNATURE		
ROBERT A. PUMPHREY, Bethesda, Maryland						MAR 27 1968					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

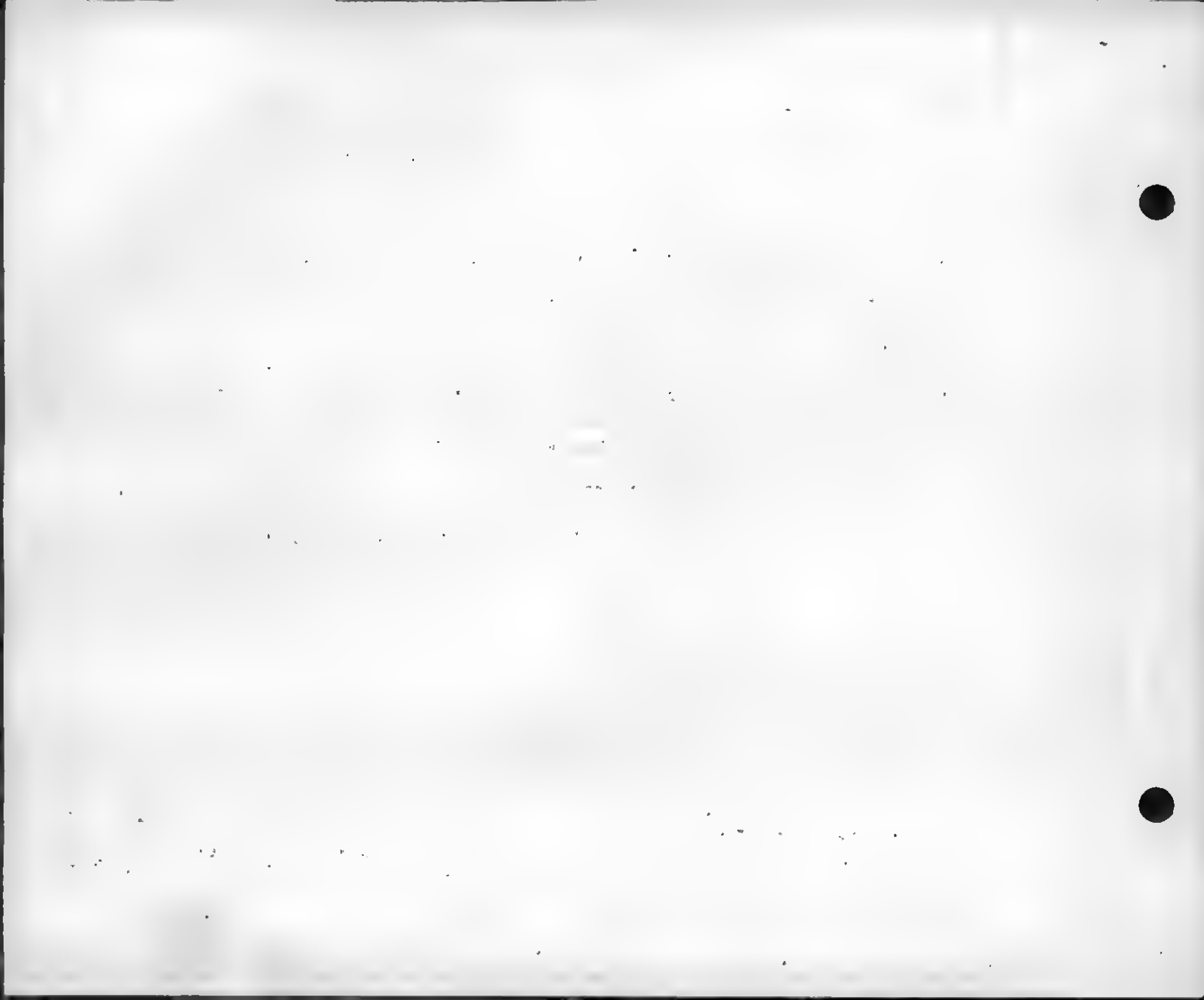
MD-286

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44473

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR A	
Kathleen		Ann	Walsh	March 29 1968		9:45 M		
3 SEX	4 RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
Female	White		6 January 1952		16 YRS.			
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Ohio	USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY		
Bethesda		The Clinical Center, NIH		Student				
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER		
Ohio				Tallmadge		1369 Newton Street		
14. FATHER'S NAME			15. MOTHER'S M.A.DEN NAME					
First Middle Last			First Middle Last					
Ronald Walsh			Grace Fike					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO		17 INFORMANT The Medical Record Address				
No		None		The Clinical Center, Bethesda, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Erosion of innominate artery with hemorrhage								8 hours
DUE TO, OR AS A CONSEQUENCE OF (b) Bronchopneumonia, left lung								2 weeks
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) Dermatomyositis and systemic lupus erythematosus								2 years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (X) (this hospital) attended the deceased from 16 March, 1968, to 29 March, 1968, that (X) (we) last saw the deceased alive on 29 March 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Gregory O. Walsh, M.D.						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 29 March 1968
22d. PHYSICIAN'S NAME (Type) Gregory O. Walsh, M. D.						22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		4-1-68		Crownhill Cemetery		Summit County, Ohio		
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland				ADDRESS		25a. REC'D BY REG STRAR DATE APR 3 - 1968		25b. REGISTRAR'S SIGNATURE Charles Judge



CERTIFICATE OF DEATH

04487

1. DECEASED NAME (Type or print) <i>Dorothy Edith Ward</i>			2a. DATE OF DEATH Month <i>March</i> Day <i>31</i> Year <i>1968</i>			2b. HOUR <i>2:35</i> M	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>2/4/92</i>		6. AGE (in years last birthday) <i>76</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Scotland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>At Home</i>		12b. KIND OF BUSINESS OR INDUSTRY - - -	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Bethesda</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>7906 Lynbrook Dr.</i>		14. FATHER'S NAME First <i>THOMAS</i> Middle <i>Blann</i> Last <i>ISABELLA MARR</i>		15. MOTHER'S MAIDEN NAME First <i>PETRIE</i> Middle <i>Blann</i> Last <i>Blann</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>		16b. SOCIAL SECURITY NO <i>608-615127</i>		17. INFORMANT <i>Rebecca Reed</i>		Address <i>same as above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>acute congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>arteriosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>41 years</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Pulmonary emphysema; massive atherosclerosis right lung</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept. 1967</i> to <i>March 31, 1968</i> , that (I) (we) last saw the deceased alive on <i>March 31, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Robert N. Coale</i>		22c. PHYSICIAN'S NAME (Type) <i>ROBERT N. COALE</i>		22d. ADDRESS <i>4429 Bradley Lane Chevy Chase Md</i>		22e. DATE SIGNED <i>March 31, 1968</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>Cremation 4-1-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		23d. LOCATION (City or Town) (County) (State) <i>Syritland Md.</i>	
24. FUNERAL DIRECTOR <i>Joseph Gawler & Sons, Inc.</i>		24a. ADDRESS <i>5130 Wisc. Ave. NW Wash. D.C.</i>		25a. REC'D BY REGISTRAR <i>Charles J. ...</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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VR A15
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <i>Walter Raymond Ward</i>			2a. DATE OF DEATH Month <i>March</i> Day <i>28</i> Year <i>1968</i>			2b. HOUR <i>9:30</i> M.	
3 SEX <i>M</i>		4 RACE <i>W</i>		5. DATE OF BIRTH <i>4-25-05</i>		6 AGE (In years last birthday) <i>62</i> YRS.	
7a BIRTHPLACE (State or foreign country) <i>North Carolina</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.C.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i> Md.	
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired Carpenter</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Maryland</i>		13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Rockville</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER <i>205 Park Road</i>		14. FATHER'S NAME First Middle Last <i>Sam Wood</i>		15 MOTHER'S MAIDEN NAME First Middle Last <i>Unknown</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b SOCIAL SECURITY NO <i>228-24-6250</i>		17 INFORMANT <i>Wife - Lula Mae - Same</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia with abscess formation</i> <i>485X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>491</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State <i>123 68 3/28/68</i>			
22a. I certify that (I) (this hospital) attended the deceased from <i>123 68</i> , 19 <i>68</i> , to <i>3/28/68</i> , that (I) (we) last saw the deceased alive on <i>3/28</i> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <i>Jay R. Shapiro</i>		22c. PHYSICIAN'S NAME (Type) <i>Jay R. Shapiro</i>		22d. ADDRESS <i>8218 Wisconsin Ave., Bethesda, Md.</i>		22e. DATE SIGNED <i>3/29/68</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>4/1/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville Montgomery Md.</i>	
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i>		ADDRESS <i>1331 Rock. Pike Rockville, Md.</i>		25a. REC'D BY REGISTRAR <i>ARK 3 - 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

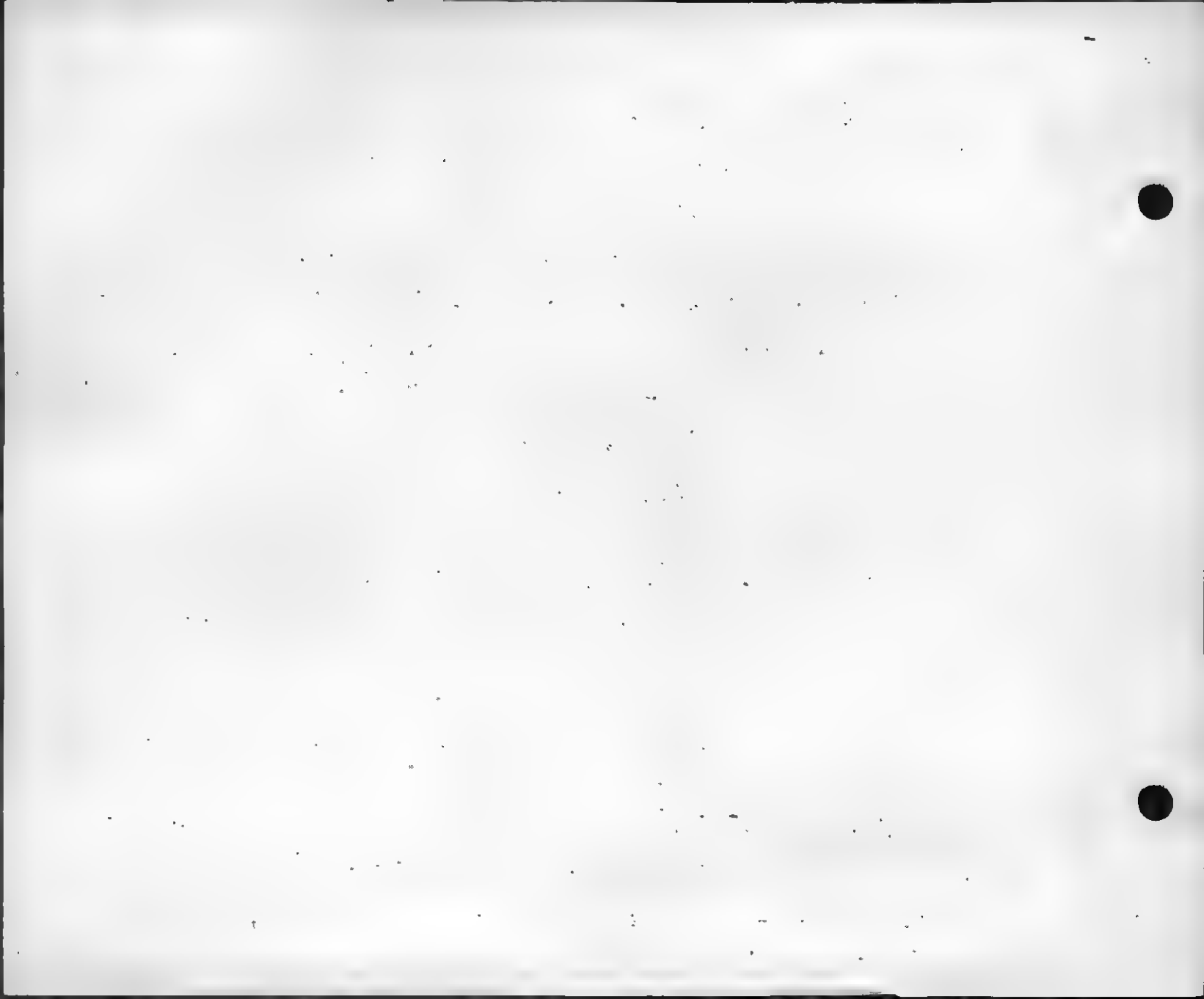


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

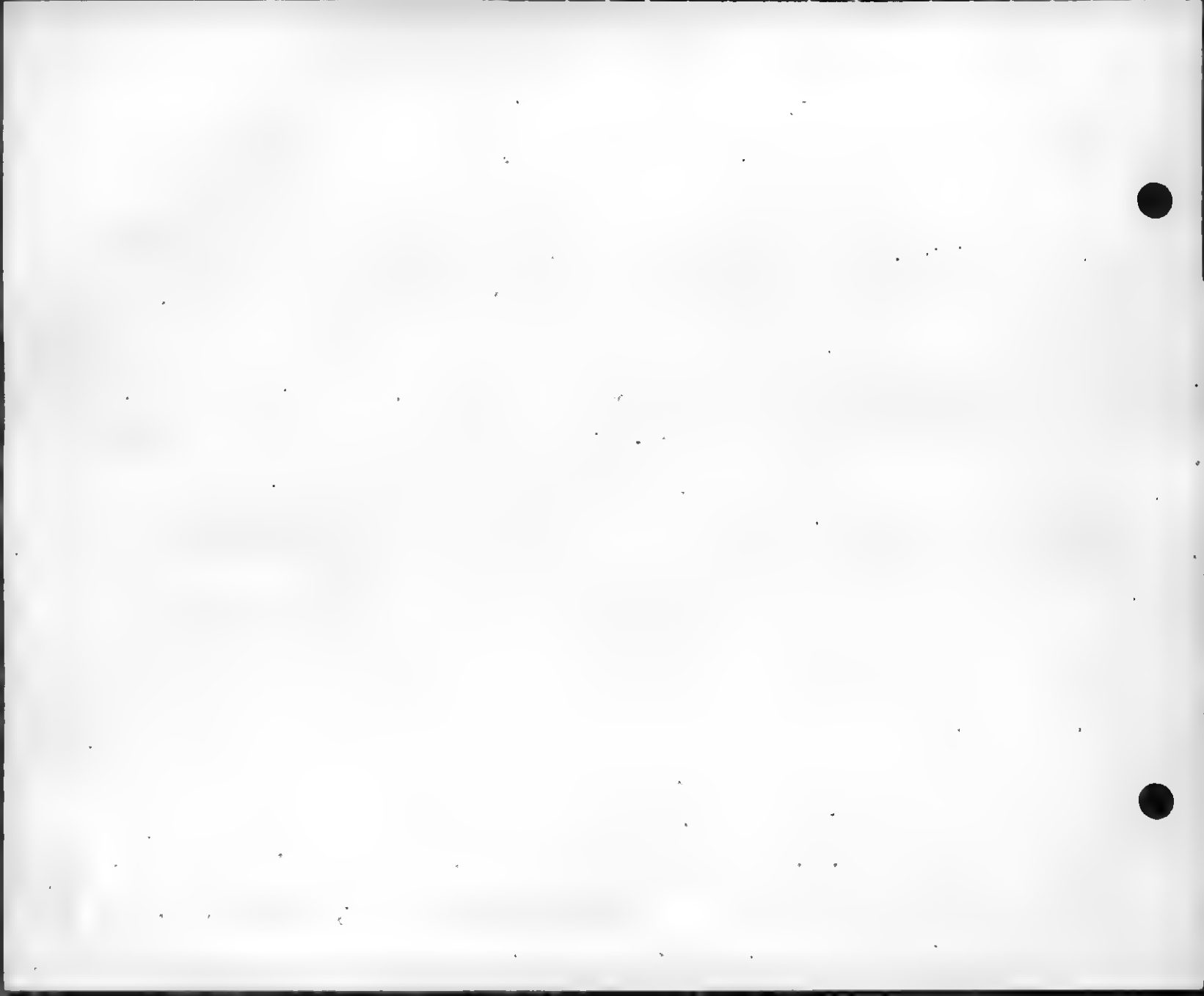
1 DECEASED NAME (Type or print) First <i>Ellen</i> Middle <i>B.</i> Last <i>Waters</i>			2a. DATE OF DEATH Month <i>3</i> Day <i>11</i> Year <i>68</i>		2b. HOUR <i>12 p.m.</i>
3 SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>9-21-76</i>		6. AGE (In years last birthday) <i>91</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (State or foreign country) <i>Md.</i>	7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i> Md.		
10. CITY OR TOWN OF DEATH <i>Wheaton</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Wheaton Nursing Home</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>	13b COUNTY <i>Montgomery</i>	13c CITY OR TOWN <i>Rockville</i>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <i>204 Monroe Street</i>	
14 FATHER'S NAME First <i>John B.</i> Middle <i>Brewer</i> Last		15. MOTHER'S MAIDEN NAME First <i>Virginia</i> Middle <i>Fletcher</i> Last <i>Russell</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i> (If yes give war or dates of service)		16b SOCIAL SECURITY NO <i>215-38-3399D</i>	17 INFORMANT <i>Sister</i> Address <i>Same as Item 13.</i>		13. <i>Elizabeth S. Brewer</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <i>Myocardial infarction</i>					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic cardiovascular disease - 2 years</i>					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Fracture right humerus about 2 months ago</i>					
19a DATE OF OPERATION <i>June</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>—</i>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year <i>19</i> P.M.	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e PLACE OF INJURY (If HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No <i>1105</i> City or Town <i>Washington</i> County <i>St.</i> State <i>Rockville, Md.</i>			
22a. I certify that (I) (this hospital) attended the deceased from <i>1950</i> , 19 <i>1950</i> , to <i>March 11, 1968</i> , that (I) (was) last saw the deceased alive on <i>3/11/68</i> , 19 <i>1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (do not) view the body after death					
22b SIGNATURE <i>Wm A Linthicum</i>		22c. DATE SIGNED <i>3/11/68</i>	22d. PHYSICIAN'S NAME (Type) <i>Wm A Linthicum</i>		
22e ADDRESS <i>1105 Washington St. Rockville, Md.</i>		22f. PHYSICIAN'S NAME (Type) <i>Wm A Linthicum</i>			
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>3-14-68</i>	23c NAME OF CEMETERY OR CREMATORY <i>Goshen Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Goshen, Maryland</i>		
24 FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		25a. REC'D BY REGISTRAR <i>DATE MAR 14 1968</i>	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
Item 22a Film G399 3/28/68 kk CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
HERMAN J WATKINS						MARCH 9 1968		4:30 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (n years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
MALE		CAUC		15 MAY 14		23 YRS.		IF UNDER 24 HRS. HOURS M.N.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md		
OHIO		USA				MONTGOMERY				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
BETHESDA			NAVAL HOSPITAL, BETH MD			NAVY MUSICIAN		USN		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD			Pro George's		CHEVERLY		YES		2418 LAKE AVE.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
DAVID WATKINS			MILDRED WINCH							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
YES			201073870		CHARLOTTE R. WATKINS 2418 LAKE AVE.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Undifferentiated mesenchymal tumor, retro-peritoneum, with metastases to brain, lung, mesentery and adrenals.										
250.7										
DUE TO, OR AS A CONSEQUENCE OF										
DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
220 r										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (X) (this hospital) attended the deceased from 21 Dec 1968 to 9 Mar 1968, that (X) (we) lost the deceased alive on 9 Mar 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (do not) view the body after death.										
22b. SIGNATURE <i>P. B. Blanchard</i> DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 10 MAR 68				
22d. PHYSICIAN'S NAME (Type) P. B. Blanchard LCDR, MC, USN						22e. ADDRESS U. S. Naval Hospital, Bethesda, MD				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Cremation		Mar 11, 1968		Fort Lincoln Crematory		Colmar Manor Pro Geo Md.				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE				
GASCH'S Funeral Home		4739 Baltimore, Md. Hyattsville, Md.		MAR 13 1968		<i>James Judge</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR					
DELORES			ALBERTA			WATSON			Month 3 Day 5 Year 68 6:30 PM					
3 SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		Colored		6-20-23			44 YRS.		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Md.			United States						Montgomery County			Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
Olney			Montgomery Gen. Hos.			House Wife								
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
Maryland			Montgomery			Sandy Spring			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Box 86, Norwood Road		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
First Middle Last			First Middle Last											
William			Dodson			Beulah			Lomack					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address					
No						Admission record, Mont. Gen. Hospital, Olney,								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
16 1 CACHEXIA											3 Mo			
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last														
(b) PULMONARY and PERICARDIAL METASTASIS											3 Mo			
DUE TO, OR AS A CONSEQUENCE OF														
(c) CARCINOMA LUNG - BRONCHOGENIC											9 Mo			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town			County State		
22a. I certify that (I) (this hospital) attended the deceased from August 1963 to 3/5, 1968, that (I) (we) last saw the deceased alive on 3/5, 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (do) (did not) view the body after death.														
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS					
Donald F. Lewis M.D.			3-6-68			D. R. LEWIS M.D.			700 CLOVERLY ST SILVERSPRING					
23a. BURIAL, CREMATION, or other disposition			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			3-10-68			Ash Memorial.,			Sandy Spring, Md.					
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Robert L. Snowden			MAR 12 1968			James J. Judge								

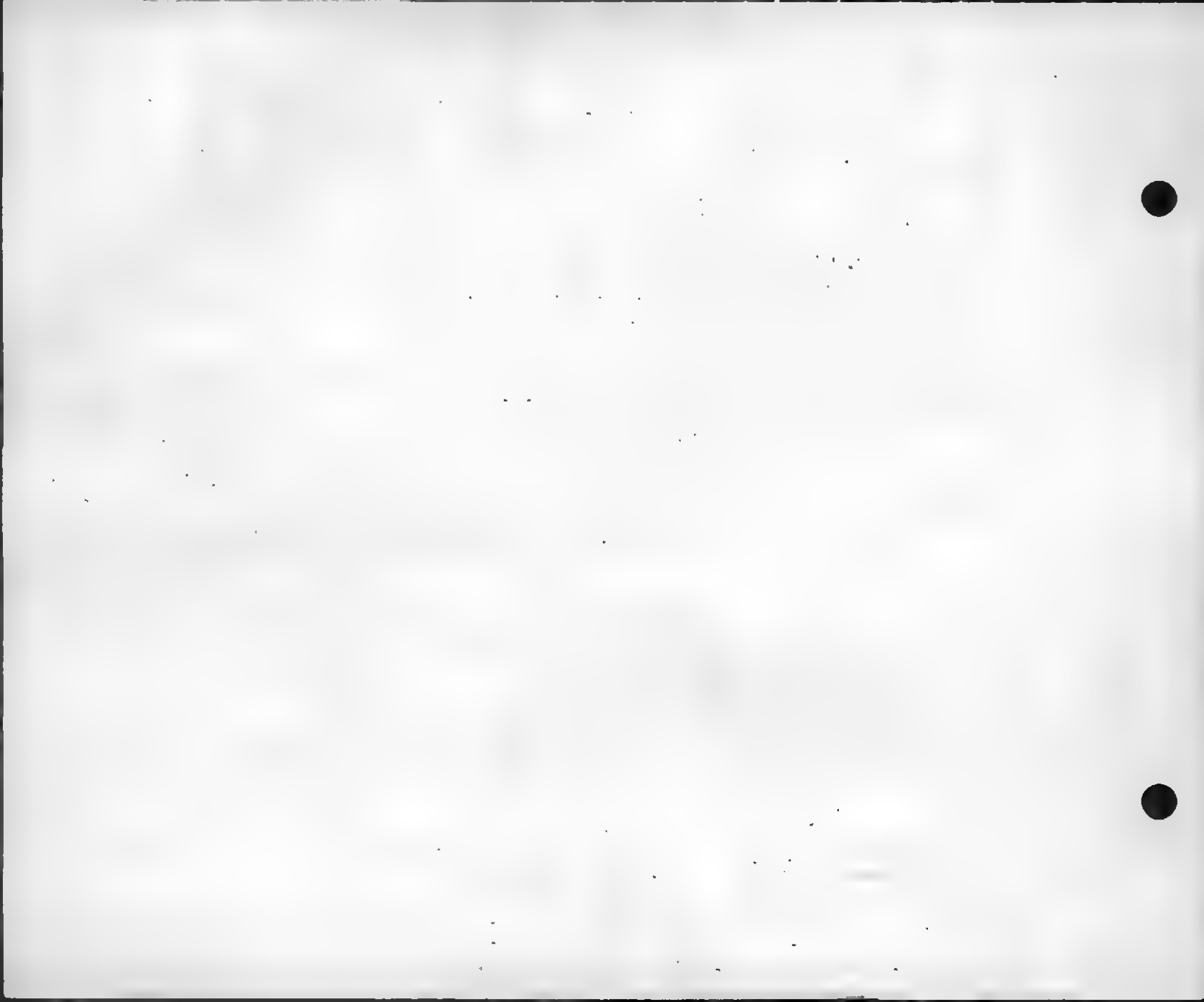


FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS, Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) MARY First Middle Last			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 3 Day 18 Year 1967 2b HOUR PM		
3 SEX Female	4 RACE Wh.	5 DATE OF BIRTH 4/10/86	6 AGE (in years last birthday) 81 YRS	7 UNDER 1 YEAR MONTHS DAYS	7 UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE md.		13b. COUNTY Montgomery		13c. STREET AND NUMBER 10800 Georgia Ave.	
14 FATHER'S NAME First James Middle E. Last Pointer			15. MOTHER'S MAIDEN NAME First Marion Middle Minor Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO yes		17 INFORMANT 4116 Great Oak Road Rockville, Maryland M.A. Weaver	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intracranial Hemorrhage due to trauma DUE TO, OR AS A CONSEQUENCE OF (b) + Subdural associated with thrombocytopenia DUE TO, OR AS A CONSEQUENCE OF (c) due to Chronic Granulocytic Anemia PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 777x					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 19 HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Belden R. Reap		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/19/1967	
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		ADDRESS (City, town or county) Baltimore, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 22, 1968		23c. NAME OF CEMETERY OR CREMATORY Lafayette Mem. Cemetery	
23d. LOCATION (City or Town) Baltimore, Maryland		23e. REC'D BY REGISTRAR MAR 26 1968		23f. REGISTRAR'S SIGNATURE James E. Humphrey, Inc.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

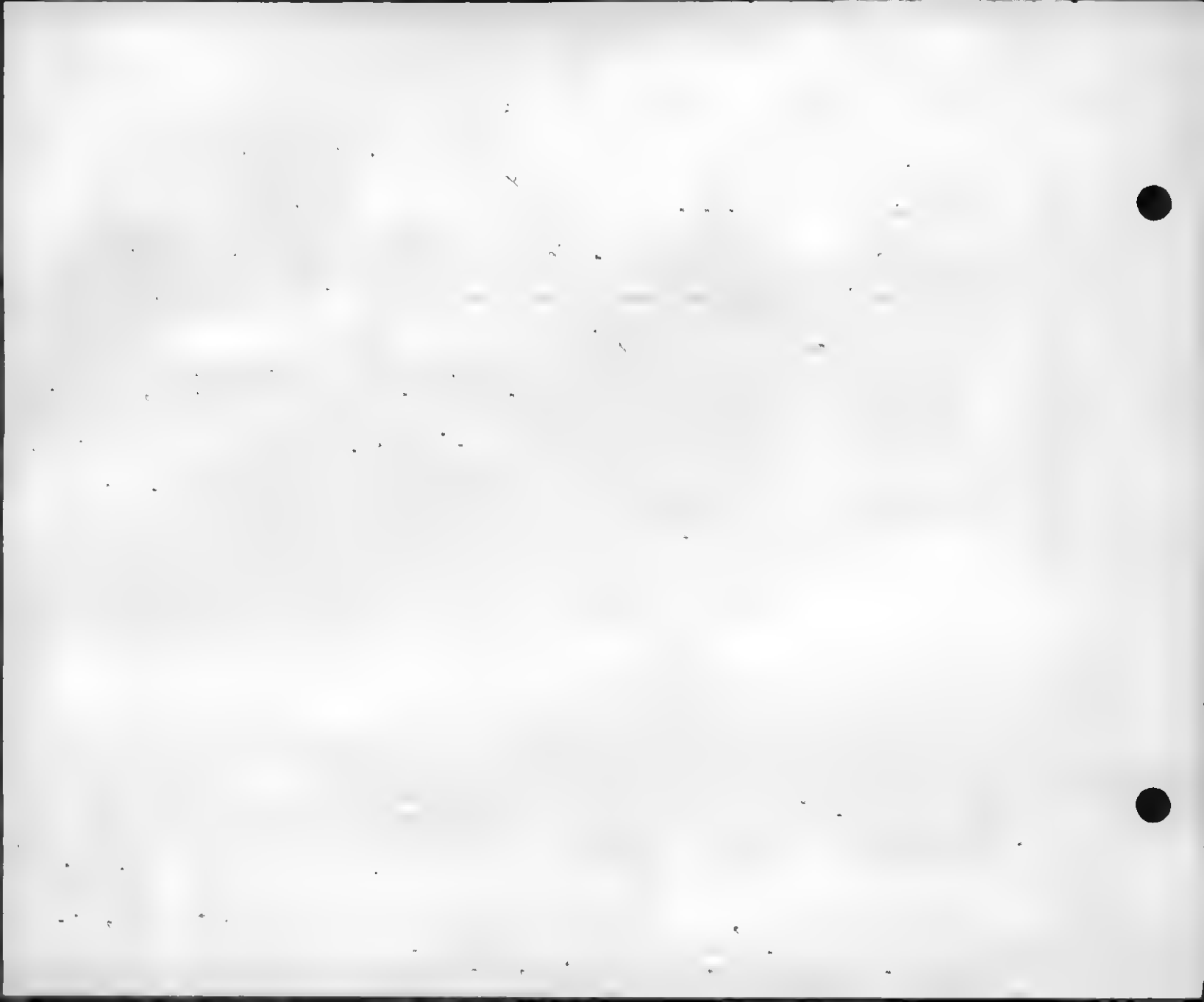
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-68

449
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Anna Middle B Last Webb			2a. DATE OF DEATH Month March Day 8 Year 1968			2b. HOUR M							
3 SEX Female		4 RACE Cauc		5. DATE OF BIRTH December 23, 1886			6. AGE (In years last birthday) 81 YRS.		F UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Missouri		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md							
10. CITY OR TOWN OF DEATH Kensington			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kensington Gardens Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY win home				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Silver Spring			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 2706 Harmon Road	
14. FATHER'S NAME First Middle Last William Schroeder				15. MOTHER'S MAIDEN NAME First Middle Last Louise Krueger									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no				16b. SOCIAL SECURITY NO. none		17. INFORMANT Mr. Elmer E. Webb 2706 Harmon Road Silver Spring, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebrovascular accident 4369 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cerebrovascular Disease 2 years DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 33X													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 1964 to 3/8, 1968, that (I) (we) last saw the deceased alive on 3/8, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Richard H. Pollen						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 3/8/68				
22d. PHYSICIAN'S NAME (Type) RICHARD H. POLLEN						22e. ADDRESS 10400 Connecticut Ave KENSINGTON							
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b. DATE March 8, 1968			23c. NAME OF CEMETERY OR CREMATORY Port Lincoln Crematory			23d. LOCATION (City or Town) (County) (State) Prince George County, Md.				
24. FUNERAL DIRECTOR C. Glen Carter Warner E. Pumphrey, Inc. Silver Spring, Md.						25. REC'D BY REGISTRAR DATE MAR 11 1968			25b. REGISTRAR'S SIGNATURE Charles J. Jones				

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

64483

1 DECEASED-NAME (Type or print) <i>KATHYRN Elizabeth Walsh</i>		First Middle Last		2a DATE OF DEATH Month <i>March</i> Day <i>9</i> Year <i>1968</i>		2b. HOUR <i>11:50 PM</i>	
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>Dec. 5 - 1935</i>		6 AGE (In years last birthday) <i>32</i> YRS	
7a BIRTHPLACE (State or foreign country) <i>MD.</i>		7b CITIZEN OF WHAT COUNTRY? <i>United States</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Belmont Nursing Home</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>housewife</i>		12b KIND OF BUSINESS OR INDUSTRY	
13a USUA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>		13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Rockville</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER <i>10401 Grosvenor Pl. Apt 920</i>		14. FATHER'S NAME First <i>August</i> Middle <i>Walsh</i> Last <i>Dorthea</i>		15 MOTHER'S MAIDEN NAME First <i>Dorthea</i> Middle <i>Dryer</i> Last <i>Dryer</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <i>none</i>		17 INFORMANT <i>Mrs. Dorothea W. Ulman Same as #13 (daughter)</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Status Epilepticus</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Vascular accident</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerosis</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>5 days</i> <i>years</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>3/8/68</i> , to <i>3/9/68</i> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <i>3/8/68</i> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death.							
22b. SIGNATURE <i>C.H. Ligon MD</i>		DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>3/10/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>C.H. Ligon MD</i>		22e. ADDRESS <i>Sandy Spring, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3/12/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Prospect Hill</i>		23d. LOCATION (City or Town) (County) (State) <i>Washington D.C.</i>	
24. FUNERAL DIRECTOR <i>Francis Gasch's Sons</i>		ADDRESS <i>Hyattsville, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>MAR 13 1968</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

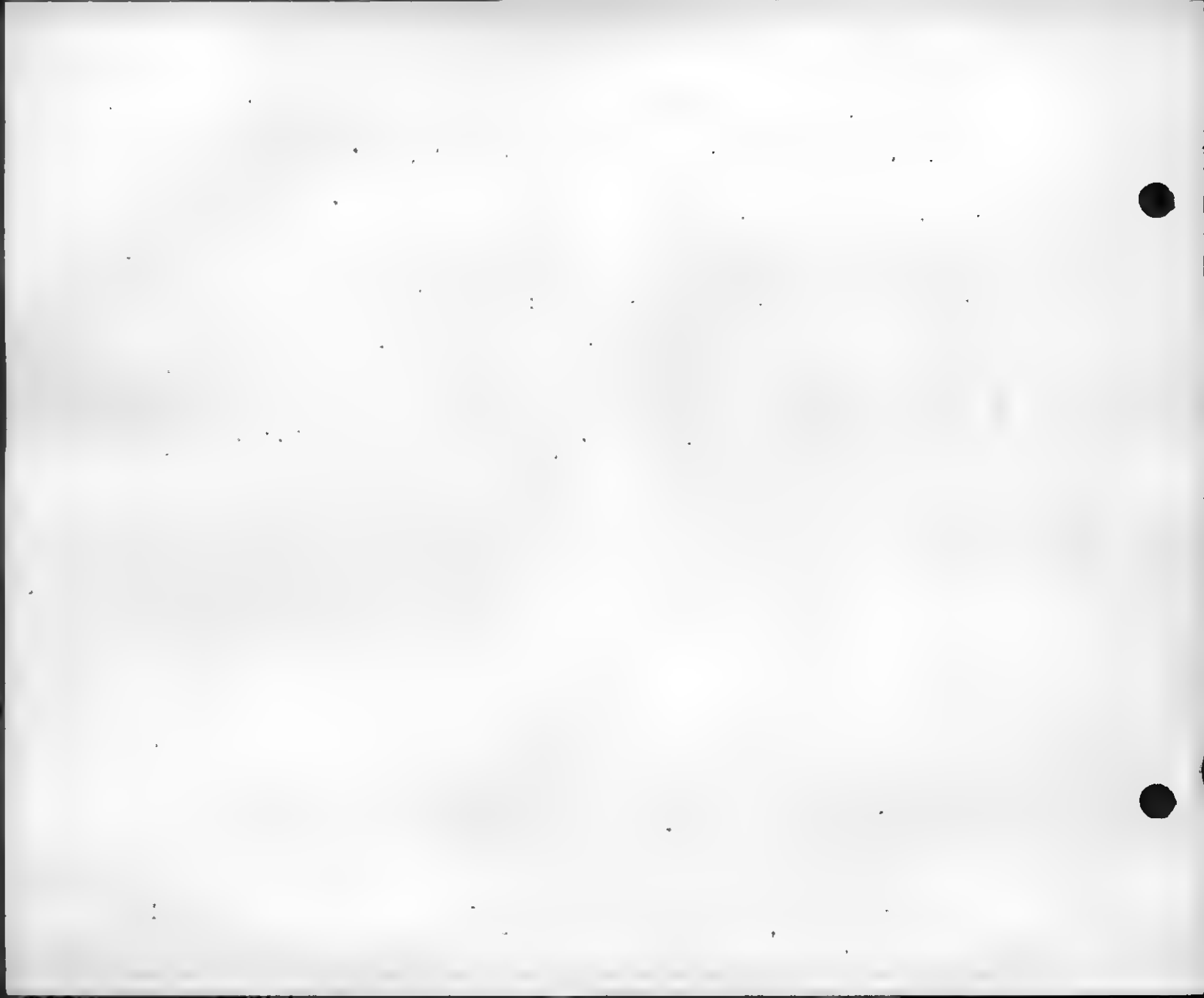


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MD-90
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last James William Wenrich			2a. DATE OF DEATH Month Day Year March 1 1968		2b. HOUR 5:40 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH March 12, 1882		6. AGE (In years last birthday) 85 YRS.	7. UNDER 1 YEAR MONTHS DAYS HOURS M.N.
7a. BIRTHPLACE (State or foreign country) Washington D.C.	7b. CITIZEN OF WHAT COUNTRY? America	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium & Hosp. Baker		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution-Residence before admission) STATE Maryland	13b. COUNTY Prince George	13c. CITY OR TOWN Hyattsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2010 Drexel Street	
14. FATHER'S NAME First Middle Last Wenrich		15. MOTHER'S MAIDEN NAME First Middle Last Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown) (If yes give war or dates of service) no -		16b. SOCIAL SECURITY NO. 579-28-8002	17. INFORMANT Address Patient's chart		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Coronary Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 2:15 P.M., 1968, to 1:10 P.M., 1968, that (I) (we) last saw the deceased alive on 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature] DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/4/68	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.	23d. LOCATION (City or Town) (County) (State) Coddman Manor, Md.		
24. FUNERAL DIRECTOR Valley's Funeral Home Inc.		ADDRESS t. Rainier Maryland	25a. REC'D BY REGISTRAR DATE MAR 6 1968		25b. REGISTRAR'S SIGNATURE [Signature]



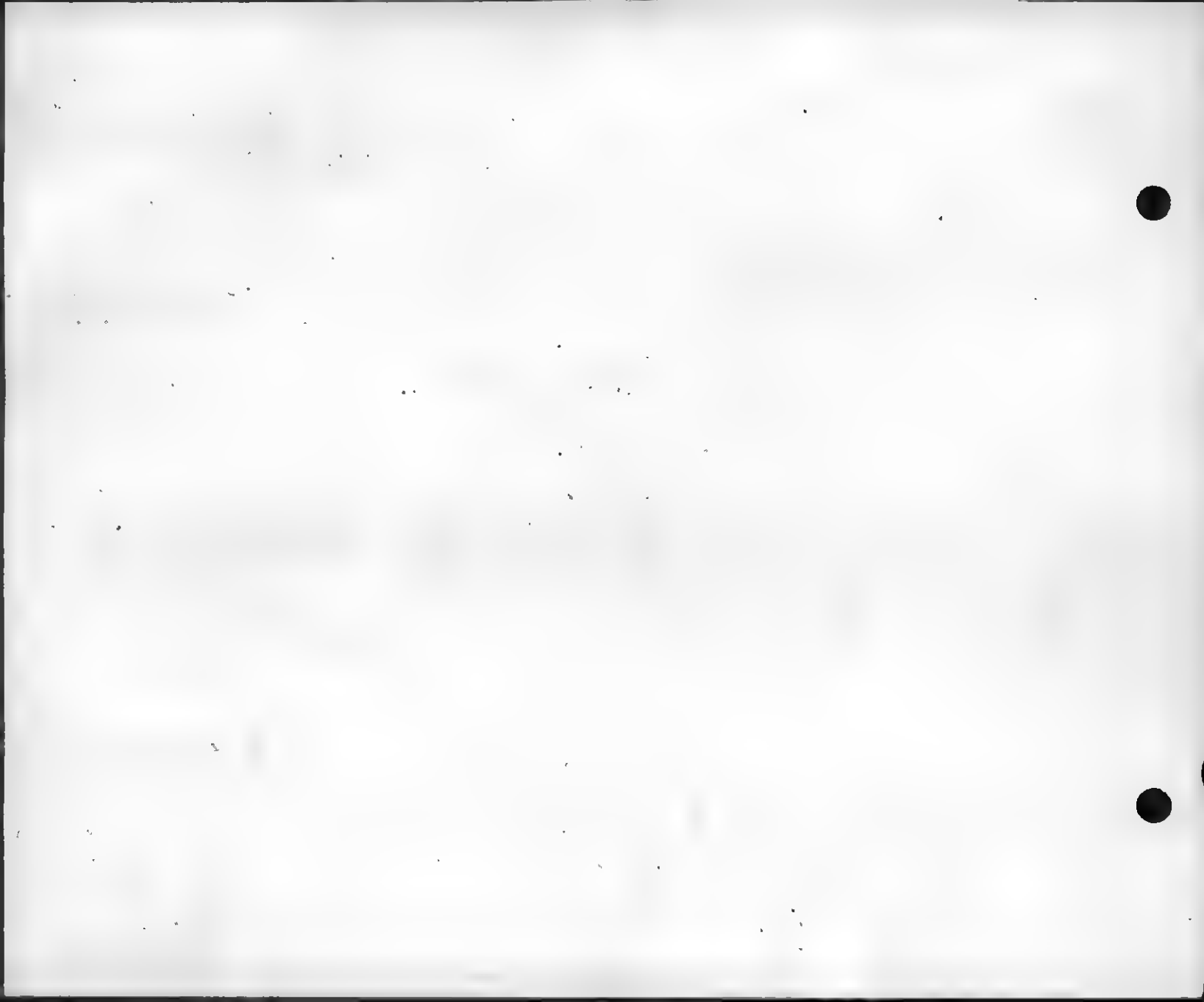
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VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Tama may Wentzel			2a. DATE OF DEATH Month Day Year March 16 1968		2b. HOUR 4:45 PM
3. SEX Fe	4. RACE Cauc.	5. DATE OF BIRTH 5 July 1980		6. AGE (In years last birthday) 88	7. UNDER 1 YEAR MONTHS DAYS 8. UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Pa.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cherry Chase Nurs. & Conv. Center	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Wash D.C.	13b. COUNTY D.C.	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 1639 North Kent St. N.W.	
14. FATHER'S NAME First Middle Last George E. Ziegler	15. MOTHER'S MAIDEN NAME First Last Alice Tressler				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO 577-46-5763	17. INFORMANT Address George C. Wentzel same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Gangrenous Decubitus Ulcers</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral Arteriosclerosis</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>1 month</u> <u>3 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 16, 1967</u> , to <u>March 16, 1968</u> , that (I) (we) last saw the deceased alive on <u>March 15, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert B. Havell M.D.	22c. DATE SIGNED March 16, 1968	22d. PHYSICIAN'S NAME (Type) Robert B. Havell M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 3/19/68	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland, Md.	23e. REC'D BY REGISTRAR DATE MAR 20 1968	
24. FUNERAL DIRECTOR H. Hines Co.		25a. ADDRESS 2901 14th NW Dr.		25b. REGISTRAR'S SIGNATURE Charles J. J...	



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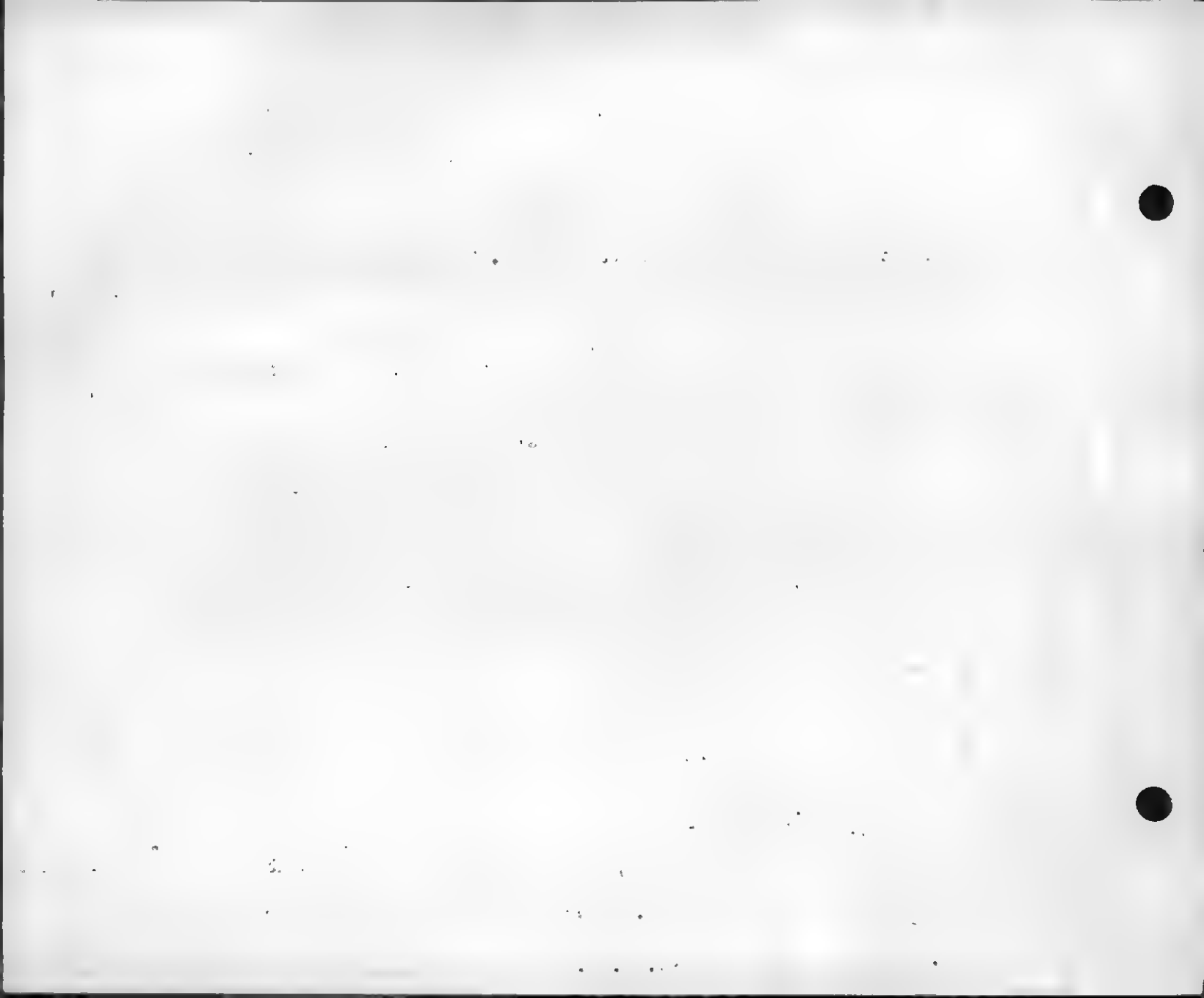
VR A 15 (1)
30A REV. 1-68

MD 298
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2b Film G399 4/25/68 kk

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Anna (None) Williams			2a DATE OF DEATH Month March Day 23 Year 1968			2b HOUR 11:08 PM	
3 SEX Female		4 RACE White		5 DATE OF BIRTH 28 January 1920		6 AGE (In years last birthday) 48 YRS	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired) Housewife		12b KIND OF BUSINESS OR INDUSTRY None	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE District of Columbia		13b COUNTY Washington		13c CITY OR TOWN Washington		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 3030 Wisconsin Ave., N.W.		14 FATHER'S NAME First Robert Middle Bowman Last Bowman		15 MOTHER'S MAIDEN NAME First Johanna Middle Davis Last Davis			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b SOCIAL SECURITY NO (If yes give war or dates of service) Not available		17 INFORMANT The Medical Record Address The Clinical Center, Bethesda, Maryland			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 2051 Bronchopneumonia and Diffuse Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 2271 (b) Chronic Myelogenous Leukemia in Blastic crisis DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Dystrophica Myotonia and Congestive Heart failure							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 Hours 1 Year
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from 6 October, 1967, to 23 March, 1968, that (X) (we) last saw the deceased alive on 23 March 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Charles M. Haskell				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 23 March 1968	
22d. PHYSICIAN'S NAME (Type) Charles M. Haskell, MD				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/27/68		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Bladensburg, Maryland	
24. FUNERAL DIRECTOR Jos. Gawler's Sons				ADDRESS 5130 Wisconsin Av Wash. D.C.		25a. REC'D BY REGISTRAR DATE MAR 27 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge			



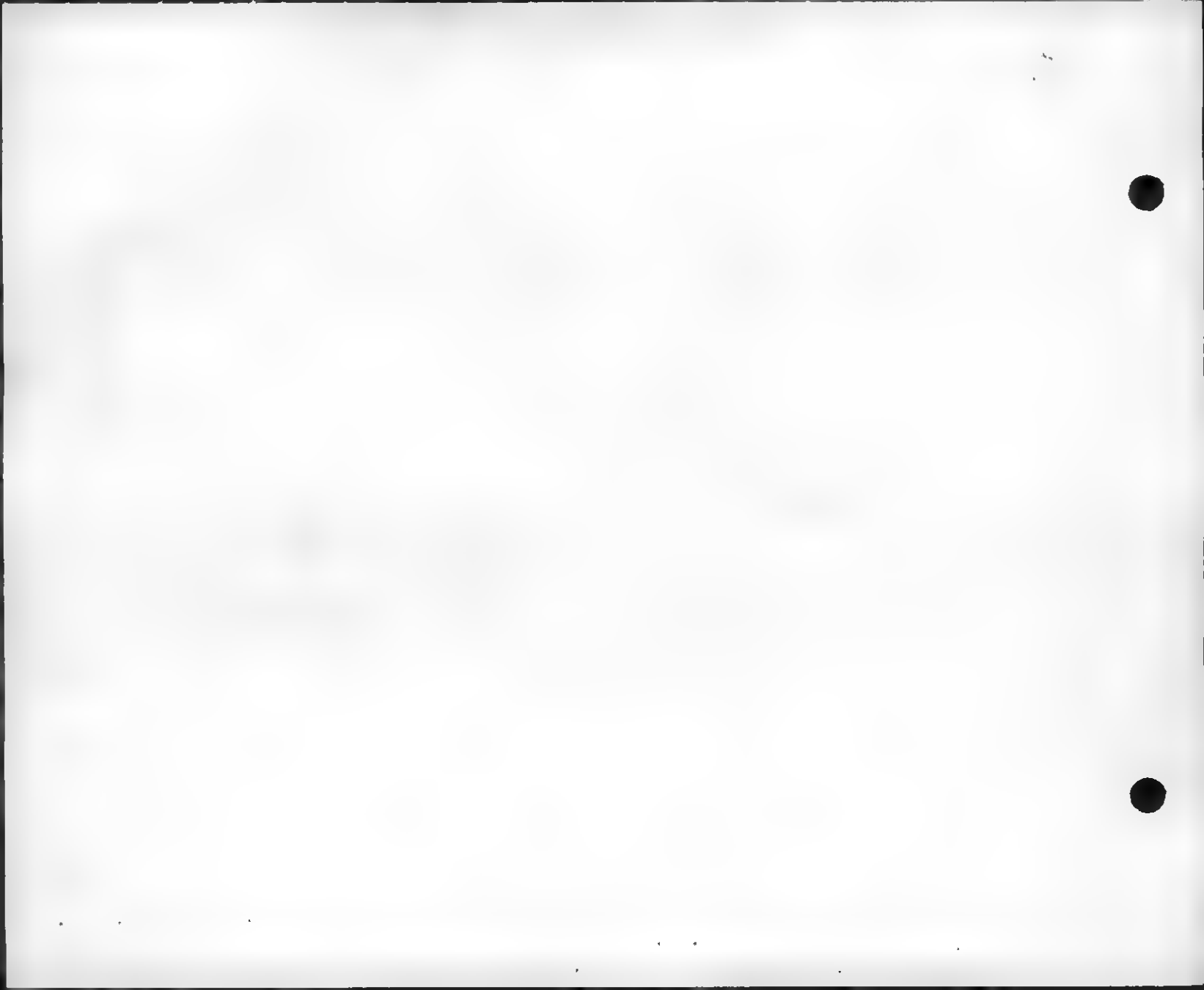
CERTIFICATE OF DEATH

84

1. DECEASED NAME (Type or print) <i>Colleen Elizabeth Wallie</i>			2a. DATE OF DEATH Month <i>March</i> Day <i>21</i> Year <i>1968</i>			2b. HOUR <i>1:15</i> M	
3 SEX <i>F</i>		4 RACE <i>W</i>		5. DATE OF BIRTH <i>3/19/67</i>		6. AGE (In years last birthday) YRS. <i>1</i> MONTHS <i>2</i> DAYS <i>2</i> HOURS <i>15</i> MIN	
7a. BIRTHPLACE (State or foreign country) <i>Tenn.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Child</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Fredrick</i>		13c. CITY OR TOWN <i>Fredrick</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>501 Prospect Blvd.</i>		14. FATHER'S NAME First <i>Albert</i> Middle <i>C</i> Last <i>Wallie</i>		15. MOTHER'S MAIDEN NAME First <i>Kathleen</i> Middle <i>Stanton</i> Last <i>Wallie</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give year or dates of service)	
16b. SOCIAL SECURITY NO <i>—</i>		17. INFORMANT <i>Albert Wallie</i>		Address <i>501 Prospect Blvd. Fredrick, Md.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia, lobar</i>		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Asthmatic bronchitis</i>		DUE TO, OR AS A CONSEQUENCE OF (c) <i>allergic deathosis.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i> <i>12 hrs</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>410x</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>3-21</i> , 1968, to <i>3-21</i> , 1968, that (I) (we) last saw the deceased alive on <i>3-21</i> , 1968, and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Richard M. Auld MD</i>				DEGREE <i>MD</i> ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>3-21-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Richard M. Auld MD</i>		22e. ADDRESS <i>809 Viers mill Rd. Rockville, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>March 23, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Calvary Memorial Park</i>		23d. LOCATION (City or Town) (County) (State) <i>Fairfax, Fairfax, Va.</i>	
24. FUNERAL DIRECTOR <i>Money & King F. H.</i> ADDRESS <i>Vienna, Virginia</i>				25a. REC'D BY REGISTRAR <i>DATE MAR 26 1968</i>		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

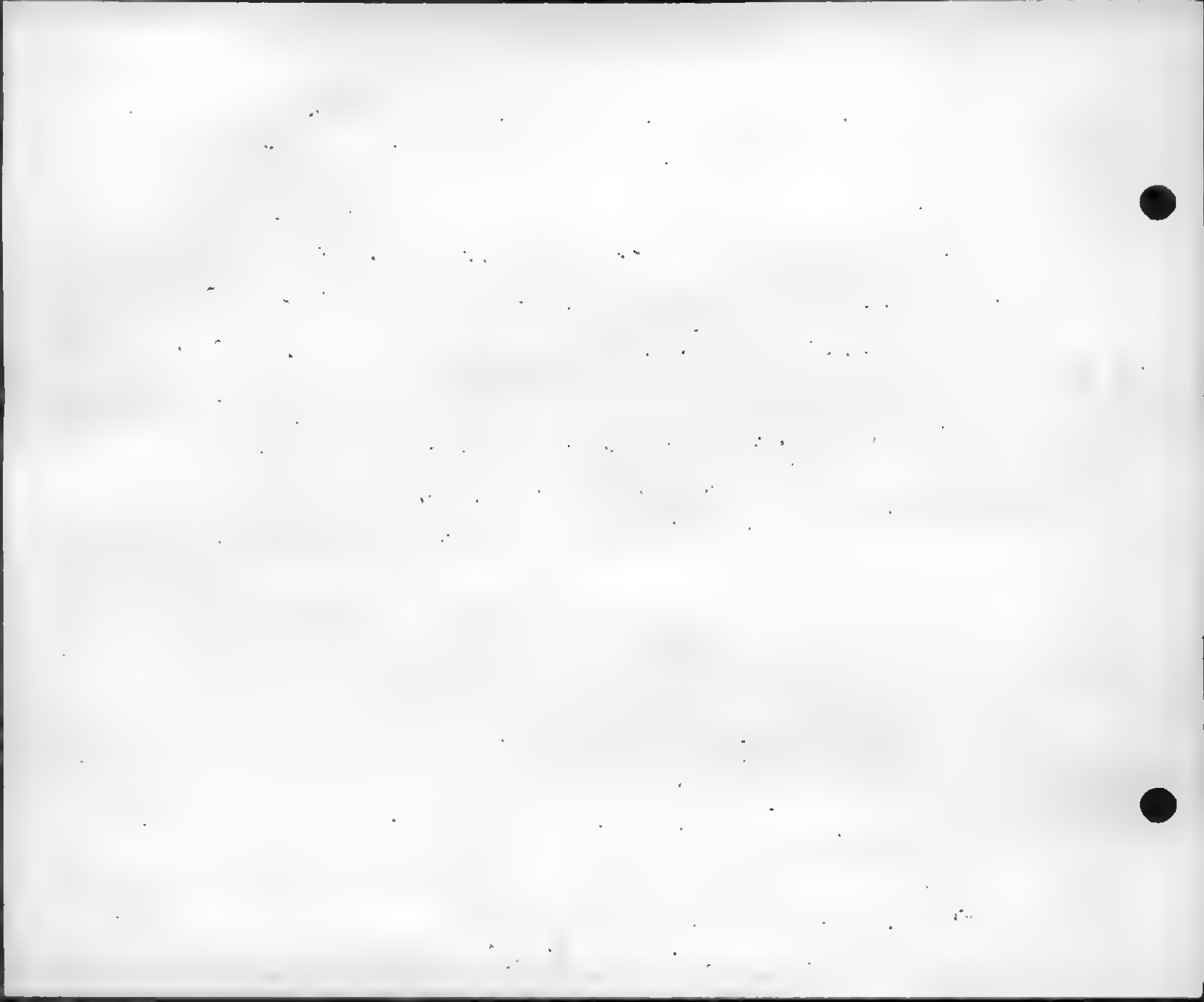


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <i>CORNELIA J. WILSON</i>			2a DATE OF DEATH <i>MAR. 14</i> Month <i>14</i> Day <i>1968</i> Year <i>3:30 PM</i>		2b HOJR
3 SEX <i>Female</i>	4 RACE <i>White</i>	5. DATE OF BIRTH <i>9/6/14</i>		6 AGE (In years last birthday) <i>53</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>D.C.</i>	7b CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	8- MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <i>Montgomery</i> Md		
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross Hosp</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>H.W.</i>	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) <i>Maryland</i> STATE <i>Montgomery</i> 13b COUNTY <i>Silver Spring</i>		13c CITY OR TOWN <i>Silver Spring</i>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <i>906 Patton Dr</i>	
14 FATHER'S NAME First <i>ERNEST</i> Middle <i>B.</i> Last <i>PRANGLEY</i>		15 MOTHER'S MAIDEN NAME First <i>ANNIE A.</i> Middle <i>STOUTEN</i> Last <i>BURGH</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i> (If yes give war or dates of service)		16b SOCIAL SECURITY NO <i>1-2 P Wilson #130</i>	17 INFORMANT <i>1-2 P Wilson #130</i> Address		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Pericardial effusion with cardiac tamponade</i> <i>174X</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastatic carcinoma in pericardium.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Inflammatory carcinoma of breast.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>174X</i>					
19a DATE OF OPERATION <i>174X</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No. City or Town County State	
22a I certify that (I) (this hospital) attended the deceased from <i>March 11, 1968</i> to <i>March 14, 1968</i> , that (I) (we) last saw the deceased alive on <i>March 14, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <i>Bernard A. Fitzgerald MD</i>		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>3-14-68</i>	
22d PHYSICIAN'S NAME (Type) <i>BERNARD A. FITZGERALD</i>		22e ADDRESS <i>247 UNIV. BLVD. SILVER SPRING MD</i>			
23a. BURIAL / CREMATION, REMOVA. (Specify) <i>Burial</i>	23b DATE <i>3/18/1968</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek</i>		23d LOCATION (City or Town) (County) (State) <i>Wash DC</i>	
24. FUNERAL DIRECTOR <i>Wm J. Altman 3603 N. 1st St. Silver Spring MD</i>		25a. RECD BY REGISTRAR <i>DAAR 18 1968</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

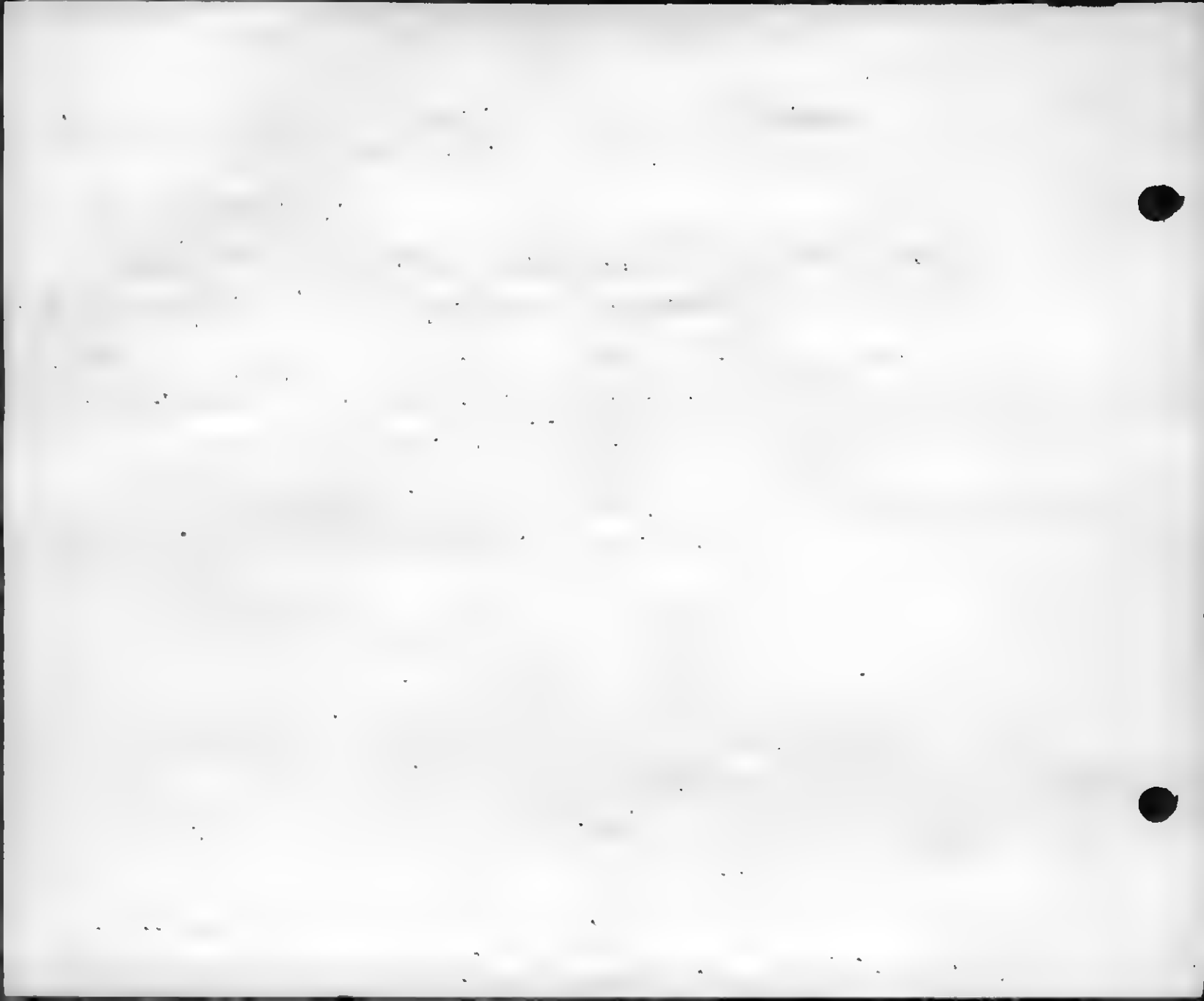


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled up by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and in any event, within 72 hours after death, should be filed with the State Dept. of Health or a burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Harold E. Wingo			2a DATE OF DEATH 3 Month 9 Day 68 Year			2b HOUR 6:50 PM			
3 SEX Male		4 RACE White		5. DATE OF BIRTH 6-8-08		6 AGE (In years last birthday) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MO.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8- MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md			
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Motion picture prod. manager		12b. KIND OF BUSINESS OR INDUSTRY DEPT. MGR.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INS. OR CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1314 Highland Dr.	
14. FATHER'S NAME First Robert Middle L. Last Wingo			15. MOTHER'S MAIDEN NAME First M. Middle Anna Last Rouse						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 499-07-9083		17. INFORMANT Mona M. Wingo Address 1314 Highland Drive Silver Spring, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Myocardial Infarction x 2 DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5-7 days 8 yrs 12-15 yrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 420.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Nov. 1960 to 9 March 1968 , that (I) (we) last saw the deceased alive on 9 March 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death									
22b. SIGNATURE Morton L. White M.D. DEGREE <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 9 March 68			
22d. PHYSICIAN'S NAME (Type) Morton L. White		22e. ADDRESS 9911 Georgia Ave, Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 12, 1968		23c. NAME OF CEMETERY OR CREMATORY Rollincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Prince Georges Co. Md.			
23e. REC'D BY REGISTRAR Warner E. C. Pumphrey, Inc.		23f. ADDRESS 8434 Georgia Ave. Silver Spring, Md.		25a. DATE MAR 14 1968		25b. REGISTRAR'S SIGNATURE [Signature]			



FOR STATE HEALTH DEPT

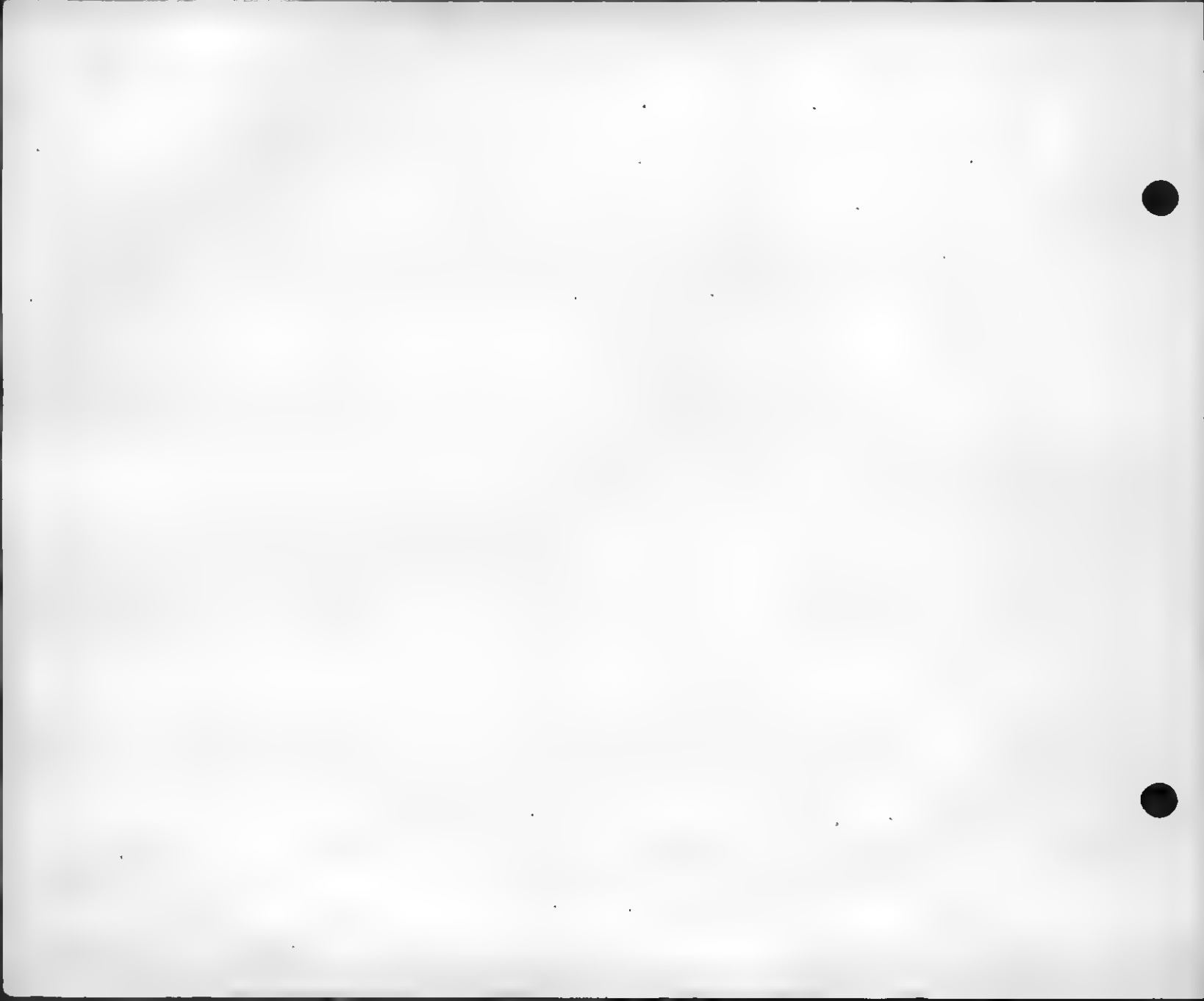
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

(Also known as - Thin Fong Yee)

MEDICAL CERTIFICATION

1 DECEASED NAME (Type or Print) AKA First Thin Fannie (NMN) Last Yee YEE										2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month MARCH Day 4 Year 1968		2b HOUR 5:00 AM							
3 SEX FEMALE		4 RACE Orient		5 DATE OF BIRTH Aug. 10, 1917		6 AGE (in years) 50 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN 		2c DATE PRONOUNCED DEAD Month MARCH Day 4 Year 1968		2d HOUR 5:00 AM					
7a BIRTHPLACE (State or foreign country) China				7b CITIZEN OF WHAT COUNTRY? U.S.A.				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 COUNTY OF DEATH Montgomery Md							
10 CITY OR TOWN OF DEATH Silver Spring				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 13017 HATHAWAY DR.				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) hswf.				12b KIND OF BUSINESS OR INDUSTRY Home							
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND				13b COUNTY Montgomery				13c CITY OR TOWN Silver Spring YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13d STREET AND NUMBER 13017 HATHAWAY DR.							
14 FATHER'S NAME First George Middle Last Yee				15 MOTHER'S MAIDEN NAME First Choydieng Middle Last Hom															
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown)				16b SOCIAL SECURITY NO 215-26-0049				17 INFORMANT MR. Henry Yee - husb				ADDRESS Same as # 13							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxiation due to aspiration of vomitus DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) 1210																			
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a EXTERNAL CAUSE WAS PR MARY <input checked="" type="checkbox"/> OR CONTR. BUT NG <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month Day Year HO - R A M 4:00 PM 3-4 19 68				21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) Deceased vomited and aspirated vomitus											
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home				21f LOCATION Street or RFD No City or Town Silver Spring County Mont State Md											
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE Belden R. Reap				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED 3/4/1968											
EXAMINER'S NAME (Type) BELOEN R. REAP MD				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town or county) 											
23a BURIAL CREMATION, REMOVAL (Specify) Burial				23b DATE March 7, 1968				23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.				23d LOCATION (City or Town) (County) (State) Colmar Manor, Md.							
24 FUNERAL DIRECTOR Lee Funeral Home 300 4th St. NE Wash., DC								ADDRESS 				25a REC'D BY REGISTRAR MAR 8 1968				25b REGISTRAR'S SIGNATURE Charles Judge			



CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Baby Boy Yeo			2a. DATE OF DEATH 3 Month 30 Day 68 Year			2b. HOUR 7:30 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 3-30-68		6. AGE (In years last birthday) YRS MONTHS 3 DAYS 17			
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13b. COUNTY Mont		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 11409 Rolling House Rd.									
14. FATHER'S NAME First Robert Middle David Last Yeo			15. MOTHER'S MAIDEN NAME First Virginia Middle Ellen Last Rood						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO None		17. INFORMANT Father Address 11409 Rolling House Rd				
18. CAUSE OF DEATH (Enter on any one cause, per line, for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Resp. Collapse							15 min		
DUE TO, OR AS A CONSEQUENCE OF (b) Prematurity							3 hrs 32		
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None									
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. None P.M. None Month None Day None Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) None					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) None		21f. LOCATION Street or R.F.D. No None City or Town None County None State None					
22a. I certify that (I) (this hospital) attended the deceased from 3-30-68 , to 3/30/1968 , that (I) (we) last saw the deceased alive on 3-30-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Tomas A. Boyle MD DEGREE MD ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c. DATE SIGNED 3-30-68					
22d. PHYSICIAN'S NAME (Type) Tomas H. Boyle MD				22e. ADDRESS 10401 Old George Town Rd Bethesda Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) 4/1/68		23b. DATE 4/1/68		23c. NAME OF CEMETERY OR CREMATORY Suburban Hospital		23d. LOCATION (City or Town) (County) (State) Bethesda-Montgomery-Md			
24. FUNERAL DIRECTOR Mrs. Amelia S. Gater Administrator ADDRESS " "				25a. REC'D BY REGISTRAR APR 3 - 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

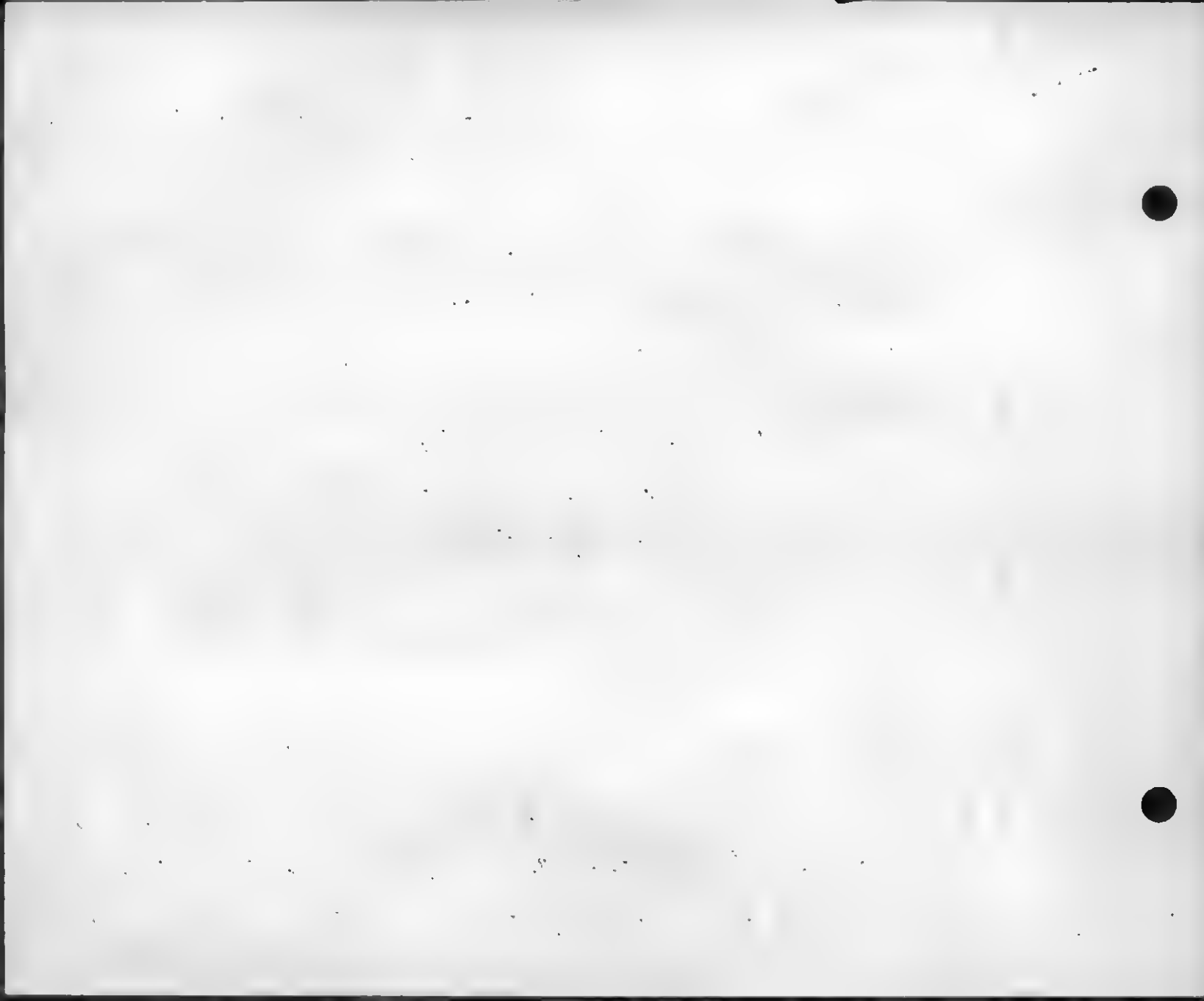


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD 500
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Joseph		First Joseph		Middle YORK		Last YORK		2a DATE OF DEATH Month March Day 6 Year 68			2b HOUR 5:45 M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH March 6, 1968			6 AGE (in years last birthday) 1 YRS. 10 MONTHS 10 DAYS		IF UNDER 1 YEAR MONTHS 1 DAYS 10		IF UNDER 24 HRS. HOURS 1 MIN 10	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md						
10 CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Bethesda		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 6012 Kingsford Rd.				
14 FATHER'S NAME First Charles Irving Middle YORK Last YORK				15 MOTHER'S MAIDEN NAME First Theresa Middle Maria Last FRITZ								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)				16b SOCIAL SECURITY NO		17 INFORMANT Father Address as above						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Rh sensitization DUE TO, OR AS A CONSEQUENCE OF (c) Incompatible Rh Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Time												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State								
22a I certify that (I) (this hospital) attended the deceased from March 6, 1968 , to March 6, 1968 , that (I) (we) last saw the deceased alive on March 6, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Robert L. Regan MD											22c DATE SIGNED 3/8/68	
22d. PHYSICIAN'S NAME (Type) Robert L. REGAN MD											22e ADDRESS 9801 GEORGIA AVE. Silver Spring Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 3/8/68		23c NAME OF CEMETERY OR CREMATORY Gate of Heaven			23d LOCATION (City or Town) (County) (State) Silver Spring, Montg. Md.					
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home Rockville, Md.												
25a REC'D BY REGISTRAR DATE MAR 11 1968											25b REGISTRAR'S SIGNATURE [Signature]	

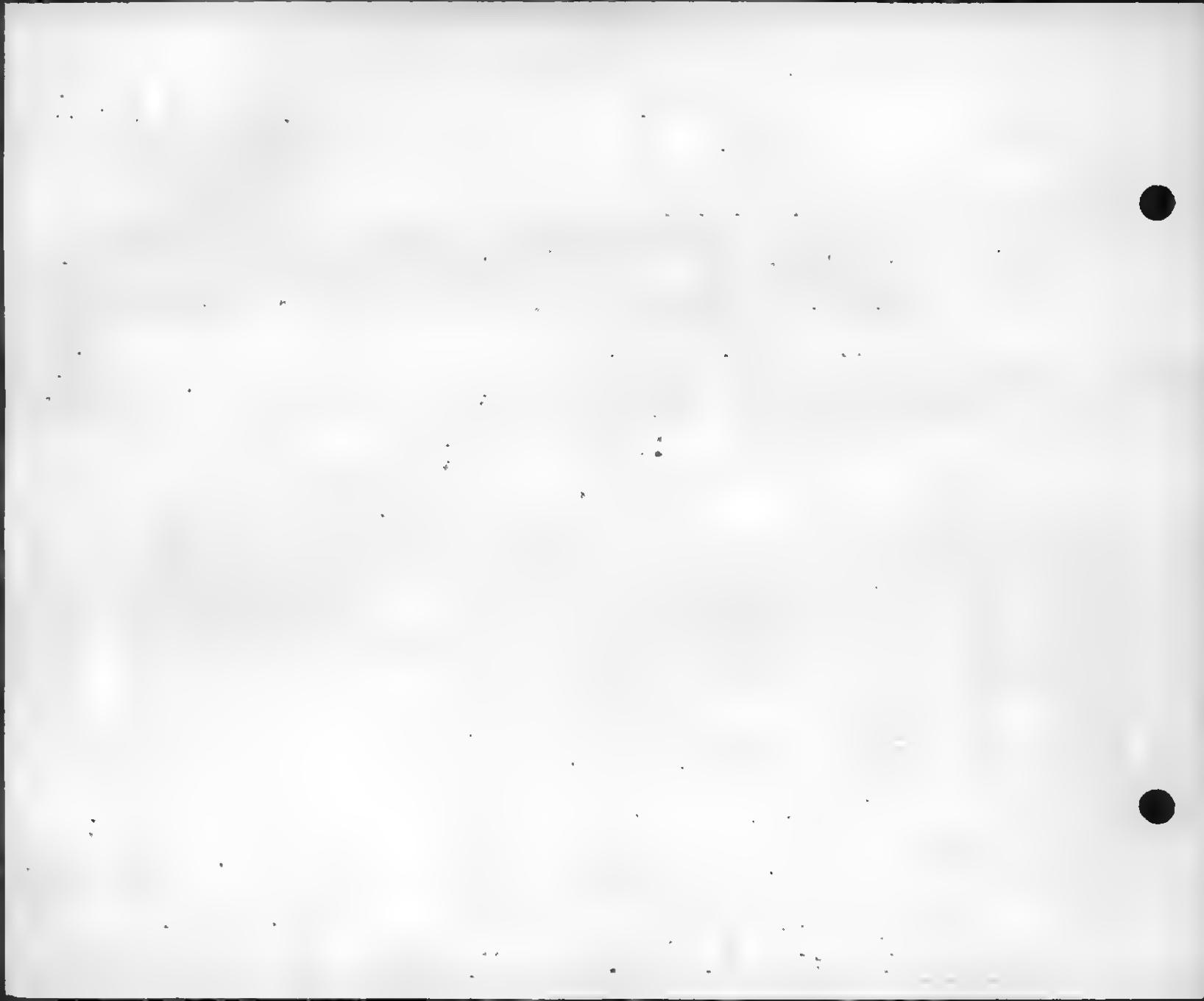


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Herman</i>			First <i>J.</i> Middle <i>J.</i> Last <i>Young</i>			2a. DATE OF DEATH Month <i>March</i> Day <i>5</i> Year <i>1968</i>			2b. HOUR <i>8:30</i> MIN <i>AM</i>		
3. SEX <i>Male</i>			4. RACE <i>White</i>			5. DATE OF BIRTH <i>May 21, 1900</i>			6. AGE (In years last birthday) <i>67</i> YRS.		
7a. BIRTHPLACE (State or foreign county) <i>Point Marion, Pa.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i> Md.		
10. CITY OR TOWN OF DEATH <i>Silver Spring, Md.</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross Hosp.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Shoe salesman</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>61 Dept. sto</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>			13c. CITY OR TOWN <i>Sil. Spring</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <i>2409 Musgrove Road</i>			14. FATHER'S NAME First <i>E.</i> Middle <i>E.</i> Last <i>Young</i>			15. MOTHER'S MAIDEN NAME First <i>Marie</i> Middle <i>Young</i> Last <i>Young</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>yes</i>			16b. SOCIAL SECURITY NO <i>77-28-5887ab</i>			17. INFORMANT <i>Elizabeth Rose Young</i>			2409 <i>Musgrove Rd.</i> <i>Silver Spring, Md.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>431.0</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertensive Cerebrovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary Arteriosclerosis</i> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last: <i>44.2x</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Arteriosclerosis - Heart - Arteritic</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>9/9/63</i> , 19 <i>63</i> , to <i>2/25/68</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>2/25/68</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Thomas F. Quinn, MD</i>			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>3/5/68</i>					
22d. PHYSICIAN'S NAME (Type) <i>Thomas F. Quinn MD</i>			22e. ADDRESS <i>11706 New Hampshire Ave. N.W. Md</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>March 8, 1968</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Washington, D. C.</i>		
24. FUNERAL DIRECTOR <i>Regil G. Carter</i>			ADDRESS <i>8434 Georgia Ave.</i>			25a. REC'D BY REGISTRAR <i>DATMAR 8 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
<i>Warner E. Humphrey, Inc.</i>			<i>Silver Spring, Md.</i>								



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-9. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) Chris Anthony ZANISON		2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 3 19 1968		2b. HOUR P. M.
3. SEX male	4. RACE white	5. DATE OF BIRTH 9/26/1920	6. AGE (In years last birthday) 47 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Rockville.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) on grounds of Montgomery Junior College.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) chem. Engineer	12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland COUNTY Montgomery	13b. CITY OR TOWN Bethesda	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET AND NUMBER 8416 West Mont Terrace	
14. FATHER'S NAME Anthony TONY ZANISON	15. MOTHER'S MAIDEN NAME MARIE - CORSAHELES	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) W.W. II		
16b. SOCIAL SECURITY NO. ---		17. INFORMANT PENNY ZANISON-WIFE-SAME AS #13 ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410.9 Acute Coronary thrombosis, left coronary artery DUE TO, OR AS A CONSEQUENCE OF (b) Coronary arteriosclerosis, severe DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus, clinical				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201 Diabetes mellitus, clinical				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE John G. Ball		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED March 21, 1968
EXAMINER'S NAME (Type) JOHN G. BALL		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
		ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 3-23-1968	23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	23d. LOCATION (City or Town) Rockville (County) Mont. (State) Md.	
24. FUNERAL DIRECTOR SOS. GAWLER'S SONS, 5130 Wisconsin Ave, NW, Washington, D.C. 20016		25a. REC'D BY REGISTRAR MAR 26 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	



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Cleared & Dr. T. Ball

MEDICAL CERTIFICATION

MONTGOMERY STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item 2 Film 0300 1/2/68 kb									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>			c. LENGTH OF STAY in 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>473</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethesda-Silver Spring Nursing Home</u>					d. STREET ADDRESS <u>2803 38th St. NW</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Theodore</u> Middle <u>—</u> Last <u>Zeiger</u>					4. DATE OF DEATH Month <u>March</u> Day <u>23</u> Year <u>1968</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1874</u>		9. AGE (In years last birthday) <u>94</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Washington</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>		
13. FATHER'S NAME <u>Unknown</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>181-20-8626A</u>		17. INFORMANT <u>Son - Leon B. Zeiger - 1819-14-50-N.W.</u>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO <u>Arteriosclerotic Vascular Disease</u> CAUSE (b) <u>4369</u> DUE TO <u>minutes</u> CAUSE (c) <u>years</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X Bronchogenic Carcinoma</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/8</u> , 1968, to <u>3/23</u> , 1968, that (I) (we) last saw the deceased alive on <u>2/24</u> 1968, and that death occurred at <u>6:30 PM</u> , from causes and on the date stated above.									
22a. SIGNATURE <u>G. Leonard Gold</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/23/68</u>		
22c. PHYSICIAN'S NAME (Type) <u>G. Leonard Gold M.D.</u>					22d. ADDRESS <u>9801 2A Ave. S.S. Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>3/25/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>King David Mem Garden</u>			23d. LOCATION (City or town) (County) (State) <u>Falls Church Va.</u>		
24. FUNERAL DIRECTOR <u>Bernard DAWZANSKY & Sons</u>					25a. REC'D BY REGISTRAR <u>301 14th St N.W. WASH - D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Mar 26 1968</u>		

